

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				65 2501		Registered No. 65 2501	
BIRTH NO. 65 2501				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Kraft, Albert				3/6/65 11:15 Am			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles General Hospital				A. STATE Maryland B. COUNTY 15-04			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. 17			
				D. STREET ADDRESS (If rural, give location) 1933 Ridgehill Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 2, 91	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Printer			10B. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Kraft				14. MOTHER'S MAIDEN NAME Annie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS 1933 Ridgehill Ave. Mr. Albert R. Kraft, Jr. Baltimore, Md. 21217	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Anterolateral Cardiac				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Vascular Disease.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/7/65 1965 to 3/6/65 1965, that (I) (we) last saw the deceased alive on 3/6/65 11:15 a.m. 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ceslino M. Alligro				23B. DATE SIGNED 3/6/65		23C. PHYSICIAN'S NAME (Type) ANSELMO M. ALLIGRO	
23D. ADDRESS North Charles General Hospital				23E. M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/9/1965		24C. NAME OF CEMETERY or CREMATORY St. Peters Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 8 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Wm. F. Jackson		25D. ADDRESS Balto. Md. 21217	

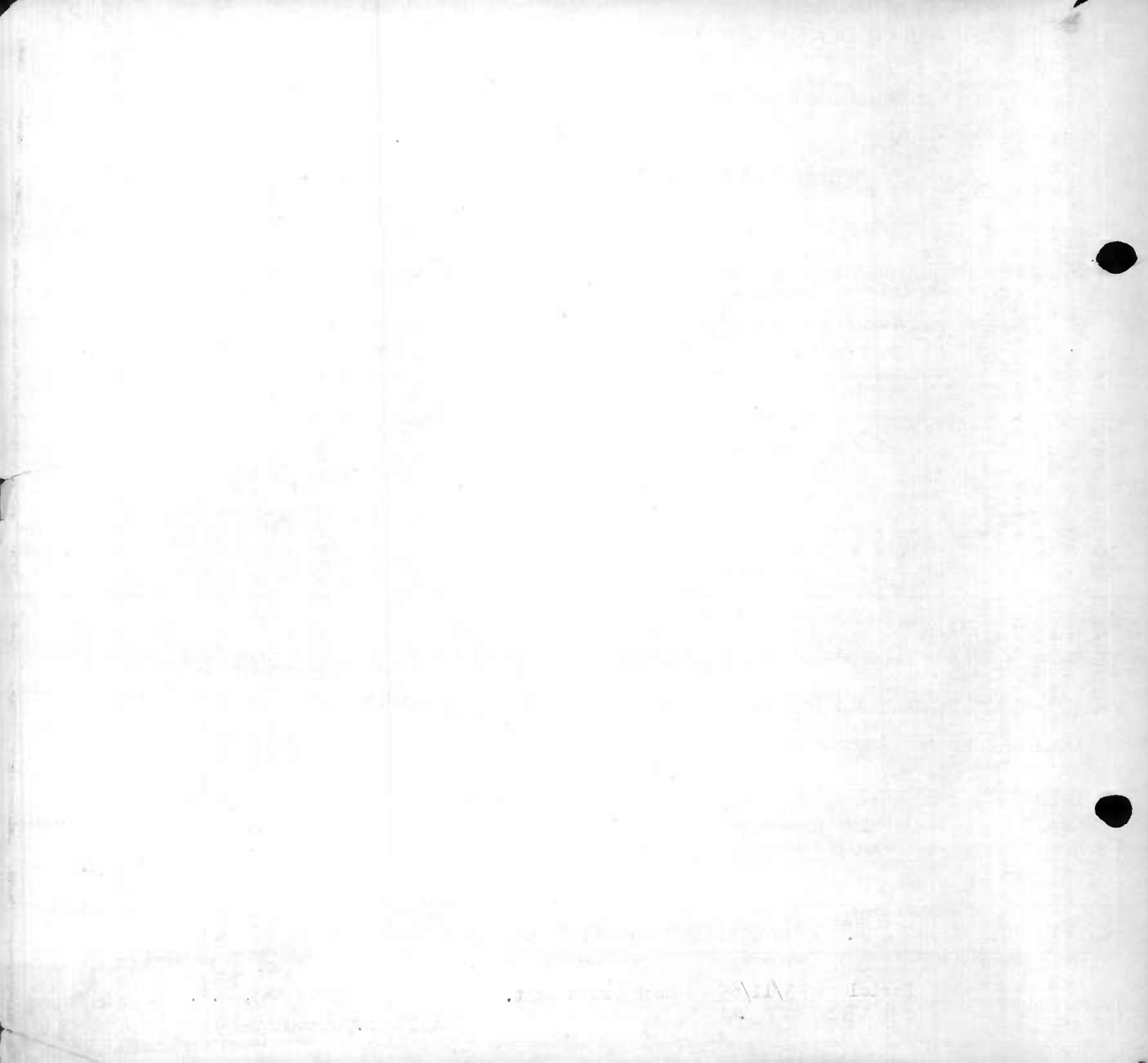




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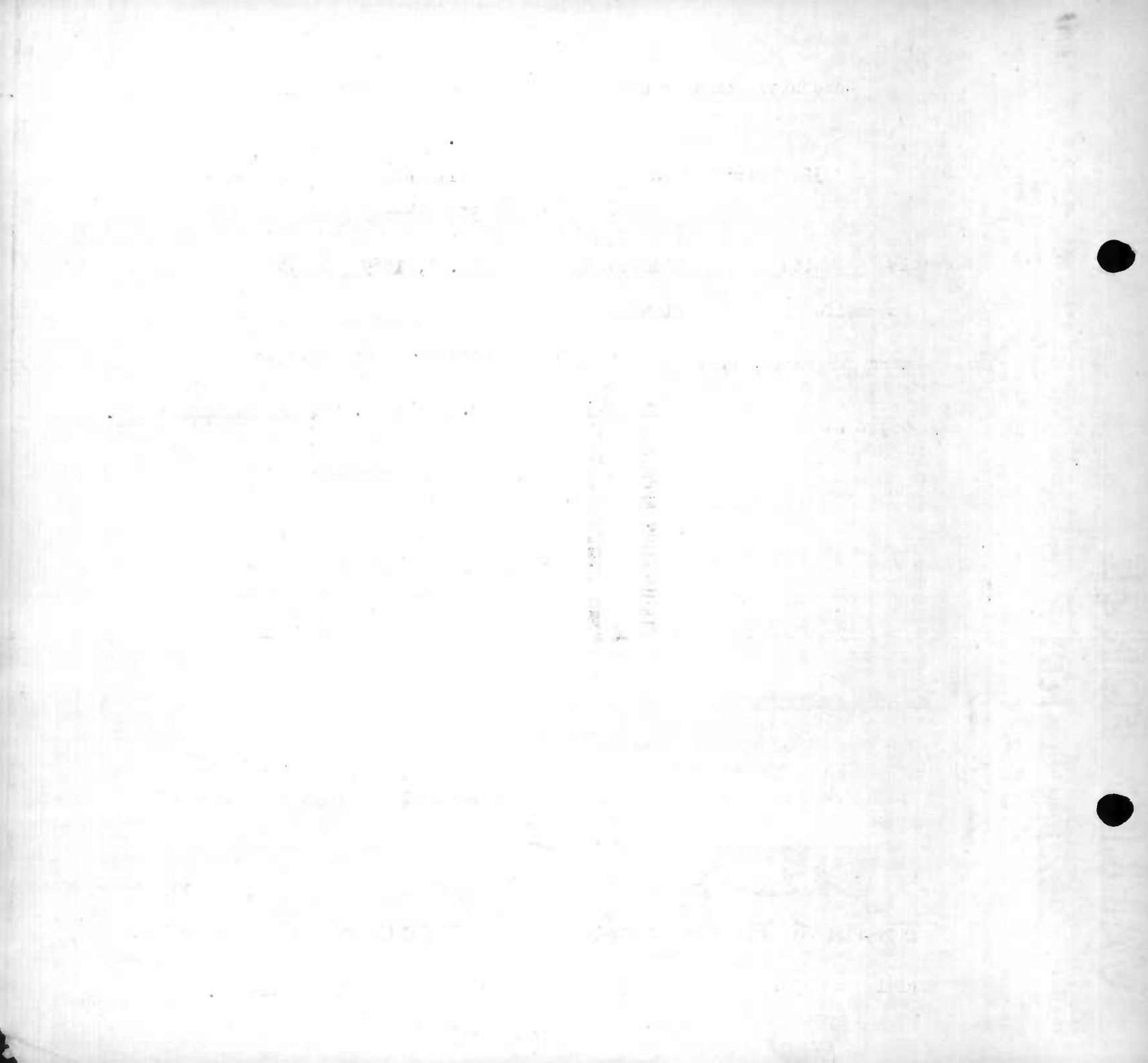
Baltimore City Health Department				Registered No.	
BIRTH NO. 65 2502		<b>CERTIFICATE OF DEATH</b>		65 2502	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Edith Dilli</b>			2. DATE AND HOUR OF DEATH <b>3-7-65 2:20 AM</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>rural (Balto. Cty.)</b> D. STREET ADDRESS (If rural, give location) <b>705 Gilmary Rd.</b>		
5. SEX <b>f</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <b>5-25-00</b>	9. AGE (In years lost birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>George L. Goodacre</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>AR sheet</b>
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>subarachnoid hemorrhage with rebleeding</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>hypertension and ASCVD</b>			INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-5-65</b> 19 to <b>3-7-65</b> 19, that (I) (we) last saw the deceased alive on <b>3-7-65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph Marr</b>				23B. DATE SIGNED <b>3-7-65</b>	
23C. PHYSICIAN'S NAME (Typed) <b>Joseph Marr</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/11/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Rock Creek Cent.</b>	
24D. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 8 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>W.R. Frank Jones 2901-14th Wash. DC</b>			



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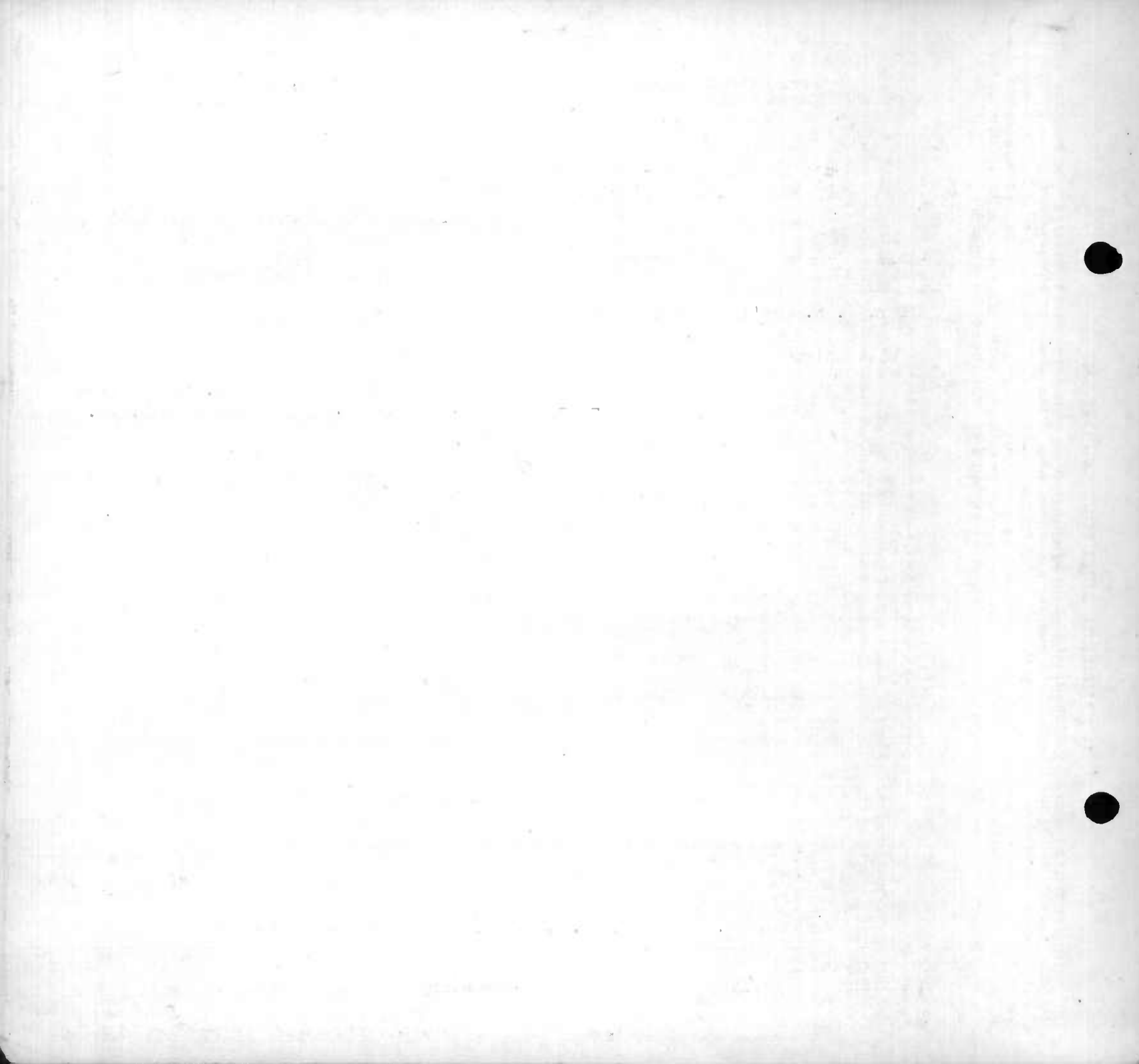
BIRTH NO. 65 2503		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2503	
M.E. CASE NO.		CERIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Josephine Stone Brooks</b>			2. DATE AND HOUR OF DEATH <b>March 4 1965</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>327 Tuscany Road</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>27-11</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>327 Tuscany Road</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Aug. 5 1889</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>Harry Prescott Stone</b>			14. MOTHER'S MAIDEN NAME <b>Josephine Mary Boucher</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Mr. Lucien B. Brooks 705 Murdock Rd.</b>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4341 + IE 900.6</b> <b>BRONCHOPNEUMONIA</b>			CAUSE OF DEATH <b>3 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Active rt humerus</b> <b>fracture of Glacoe (12)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Church</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>86 Peters Church Balt.</b>	
21D. TIME OF INJURY (APPROX.) <b>JAN 31 65 10:30</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Tripped on stairs</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>March 4 1965</b> to <b>March 4 1965</b> , that (I) (we) lost saw the deceased alive on <b>March 4 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edwin J. Berstock</b>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>March 5/65</b>
23C. PHYSICIAN'S NAME (Type) <b>EDWIN J. BERSTOCK</b>			23D. ADDRESS <b>3500 N. CALVERT ST Balt. Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/6/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge</b>	
24D. LOCATION (City, town, or county) (State) <b>Pikesville Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>William J. Doherty &amp; Sons North Penna Ave</b>	



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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2504	
BIRTH NO. 65 2504				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Pearl Catron DeRake</b>			2. DATE AND HOUR OF DEATH <b>March 4, 1965</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>House in the Pines - Belvedere 2525 West Belvedere Avenue</b>			A. STATE <b>Maryland</b> B. COUNTY <b>15-10</b>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			D. STREET ADDRESS (If rural, give location) <b>4015 Kathland Avenue 21207</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>6/4/1878</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk U. S. Gov't</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <b>Will Catron</b>		
14. MOTHER'S MAIDEN NAME <b>Lucy Tate</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>		
16. SOCIAL SECURITY NO. <b>216-22-4354D</b>			17. INFORMANT ADDRESS <b>Mr. Charles C. Grey Falls Church, Va.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Angiostenosis</b>			DUE TO <b>arteriosclerosis</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 10, 1963</b> to <b>March 4, 1965</b> , that (I) (we) lost saw the deceased alive on <b>March 19, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Lester N. Kolman</b>			23B. DATE SIGNED <b>March 6, 1965</b>		
23C. PHYSICIAN'S NAME (Type) <b>Lester N. Kolman, M.D.</b>			23D. ADDRESS <b>3700 Park Heights Avenue</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>3/9/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Crematory</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 8 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Wm. Fisher and son</b>			
25D. ADDRESS <b>Baltimore, Md. 17 North &amp; Pa. ave</b>					

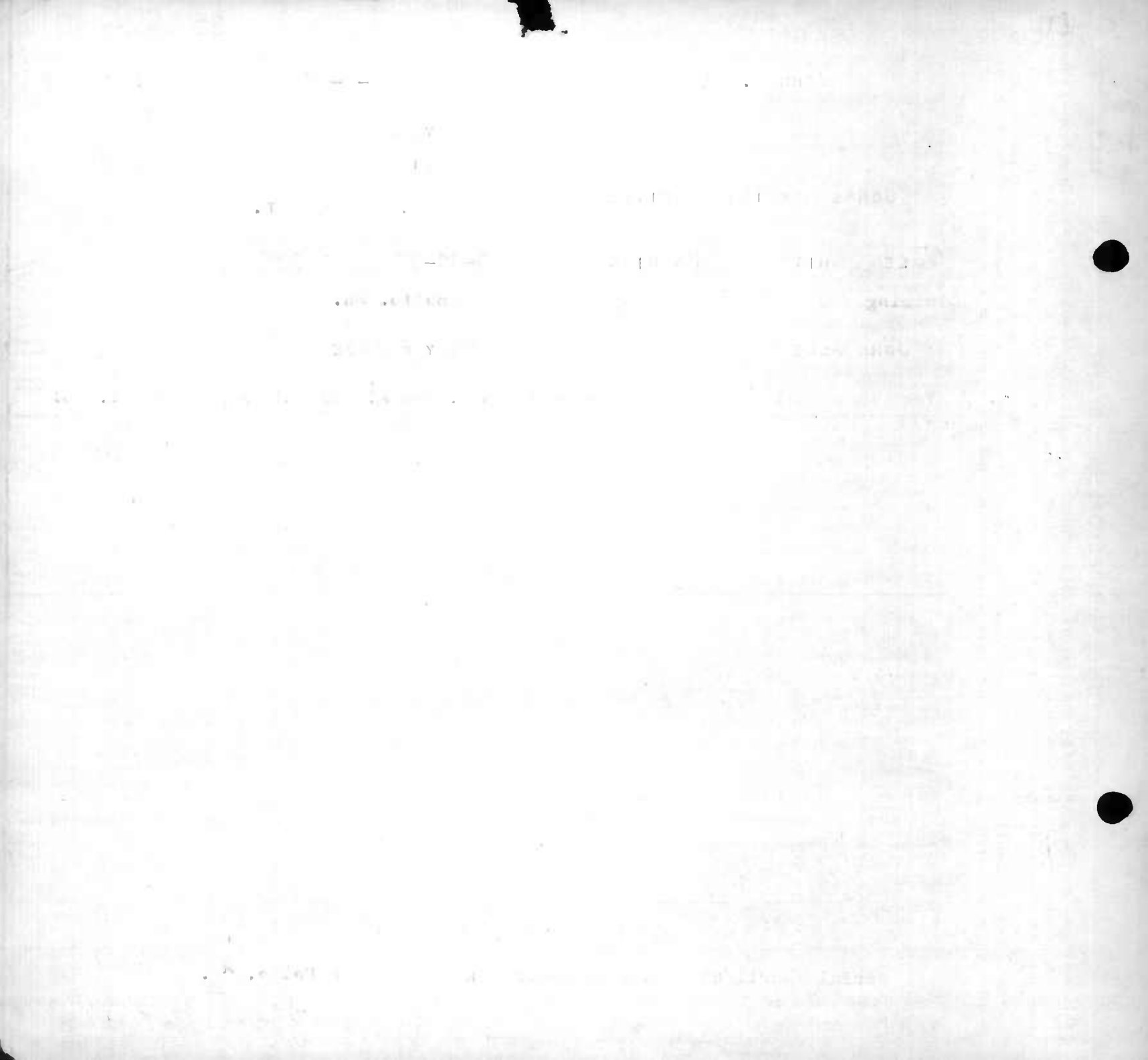


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BIRTH NO. 65 2505		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2505	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHN P. ALLS		2. DATE AND HOUR OF DEATH 3-7-65 6:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 6-04			
		D. STREET ADDRESS (If rural, give location) 213 N. CASTLE ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-11-92	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME JOHN ALLS		14. MOTHER'S MAIDEN NAME MARY FREEDE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 217-01-4249		17. INFORMANT ADDRESS Mrs. Eva M. Alls 213 N. Castle St. 31	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) cerebrovascular accident. INTERVAL BETWEEN ONSET AND DEATH 2 months.		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. urinary retention		10 days.			
19A. DATE OF OPERATION 0 None -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/25 19 65 to 3/7 19 65, that (I) (we) last saw the deceased alive on 3/7 5:45 pm 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard Kosto		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/7/65	
23C. PHYSICIAN'S NAME (Type) BERNARD KOSTO		23D. ADDRESS 601 N. Broadway Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Mar 11/65		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 8 1965		25B. NAME OF REGISTRAR P. C. E. Tolson	
25C. FUNERAL DIRECTOR Phelps Newby Sons 2024 Orleans St		25D. ADDRESS			





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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2506	
BIRTH NO. 65 2506					
M.E. CASE NO. 65 2506					
1. NAME OF DECEASED (Type or Print) <b>Minnie S. Blaney</b>			2. DATE AND HOUR OF DEATH <b>3/4/65 6:05p.m.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Union Memorial Hospital</b>			A. STATE <b>Md</b> B. COUNTY <b>12-03</b>		
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>			8. DATE OF BIRTH <b>12/23/82</b> 9. AGE (in years last birthday) <b>82</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Henry Long</b>			14. MOTHER'S MAIDEN NAME <b>Hix, Sue M.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Mr. I. D. Long</b>			ADDRESS <b>3811 Garrison Boulevard Baltimore, Md. 21215</b>		
18. <b>331X I</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) DUE TO <b>CVA</b>		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(B) DUE TO		
ANTECEDENT CAUSES			(C) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH <b>7 hours?</b>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (at this hospital) attended the deceased from <b>3/4/1965</b> to <b>3/4/1965</b> , that (we) last saw the deceased alive on <b>3/4/1965</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (the) view the body after death.					
23A. SIGNATURE <b>William B. Long</b>			23B. DATE SIGNED <b>3/4/65</b>		
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM B. LONG</b>			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/8/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION <b>Woodlawn, Maryland</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR <b>... Baltimore ...</b>	

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
65 2507						65 2507	
M.E. CASE NO.				2. DATE AND HOUR PRONOUNCED DEAD			
1. NAME OF DECEASED (Type or Print)				March 6, 1965 7:27 A.M.			
CARL PAULLEY (F.)							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
SOUTH BALTIMORE GENERAL HOSPITAL				Virginia Tazewell Co.			
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
				N. Tazewell			
				D. STREET ADDRESS (If rural, give location)			
				Route 1 - Box 184-N RFD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs.		
Male	White	Widowed	May 14, 1908	56	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ret. Coal Miner		Coal Mining		Bland County, Va.		U S A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Paulley				Nanny Wattle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS (Son)			
No		233-12-8980		Carl S. Paulley 1029 Church St Baltimore Md 21225			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Constrictive pericarditis			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Active pulmonary tuberculosis, pulmonary emphysema and rheumatic heart disease			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
John E. Adams, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED				3-6-65			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		March 10 65		Cedar Hill Cemetery		Brooklyn A A Co., Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
MAR 8 1965		Robert E. Taylor		Curtis E. Evans		1400 S Charles St Baltimore Md 21230	

CURTIS E. EVANS

*[Handwritten signature]*

VALLEY FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

SAB-42-87-20 E-1-87-20				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 2508</u>	
BIRTH NO. <u>65 2508</u>		<b>CERTIFICATE OF DEATH</b>					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Baby Girl Evans-<del>Do</del></u>		2. DATE AND HOUR OF DEATH <u>2-12-1965</u> <u>10</u> <u>P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland-21224</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>(Rural) 5300</u> D. STREET ADDRESS (If rural, give location) <u>9 Cottage Avenue, 21222</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>2-12-1965</u>	9. AGE (In years last birthday) <u>20</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. <u>20</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Rose Evans</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Records: BCH-4940 Eastern Avenue, 21224</u>			
18. <u>761.5-1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <u>Anoxia</u> DUE TO (B) <u>Prematurity</u> DUE TO (C) <u>Placenta Previa</u>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>2-12-1965</u> to <u>2-12-1965</u> , that (I) (we) last saw the deceased alive on <u>2-12-1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>S. Wayne Klein</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>2-12-1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. S. Wayne Klein</u>				23D. ADDRESS <u>4940 Eastern Avenue, Baltimore, Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremated</u>		24B. DATE <u>3/5/1965</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore City Hospitals</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>2514</u>		ADDRESS	

2 pages Klem



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2509</u>	
<div style="display: flex; justify-content: space-between;"> <span>cdg: 46-92-18</span> <span>65-03872</span> <span>2509</span> </div>					
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Ward, Baby Boy-- <del>Dorinda</del>		February 23, 1965   11:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland 6-02			
5. SEX		6. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		2-22-65		1	
7. RACE		8. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		10. AGE (In years last birthday)	
Negro		Single		1	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
				USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				RECORDS: BCH 4940 Eastern Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II		(A) Membrane Hyaline Syndrome		30 hours	
ANTECEDENT CAUSES		(B) Prematurity			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				Yes	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from February 22, 1965 to February 23, 1965, that (I) (we) last saw the deceased alive on February 23, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
S. Wayne Klein				2-23-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
S. Wayne Klein				4940 Eastern Avenue 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Cremated		3/3/1965		Baltimore City Hospitals	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 8 1965		Robert E. Bailey, M.D.		2515	



5-163 1 65 2510 BALTIMORE CITY HEALTH DEPARTMENT 65 2510

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) <b>Henry W. Sheppard</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>3-4-65 1 5:45 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Franklin Square Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1407 W. Fayette St.</b>	
5. SEX <b>male</b>	6. RACE <b>colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 31, 1909</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	9. AGE (In years last birthday) <b>.55</b>
13. FATHER'S NAME <b>John Sheppard</b>		11. BIRTHPLACE (State or foreign country) <b>Bolden N.C.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <b>no</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Grate</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mary Logan 421 Poplar Grove St.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Bilateral confluent bronchopneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Pulmonary emphysema</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held an inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>March 8/65</b>	
23C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		23D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>MAR 8 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>	
		24C. FUNERAL DIRECTOR <b>Williams Funeral Home 3197 Schrock St.</b>	
		ADDRESS	

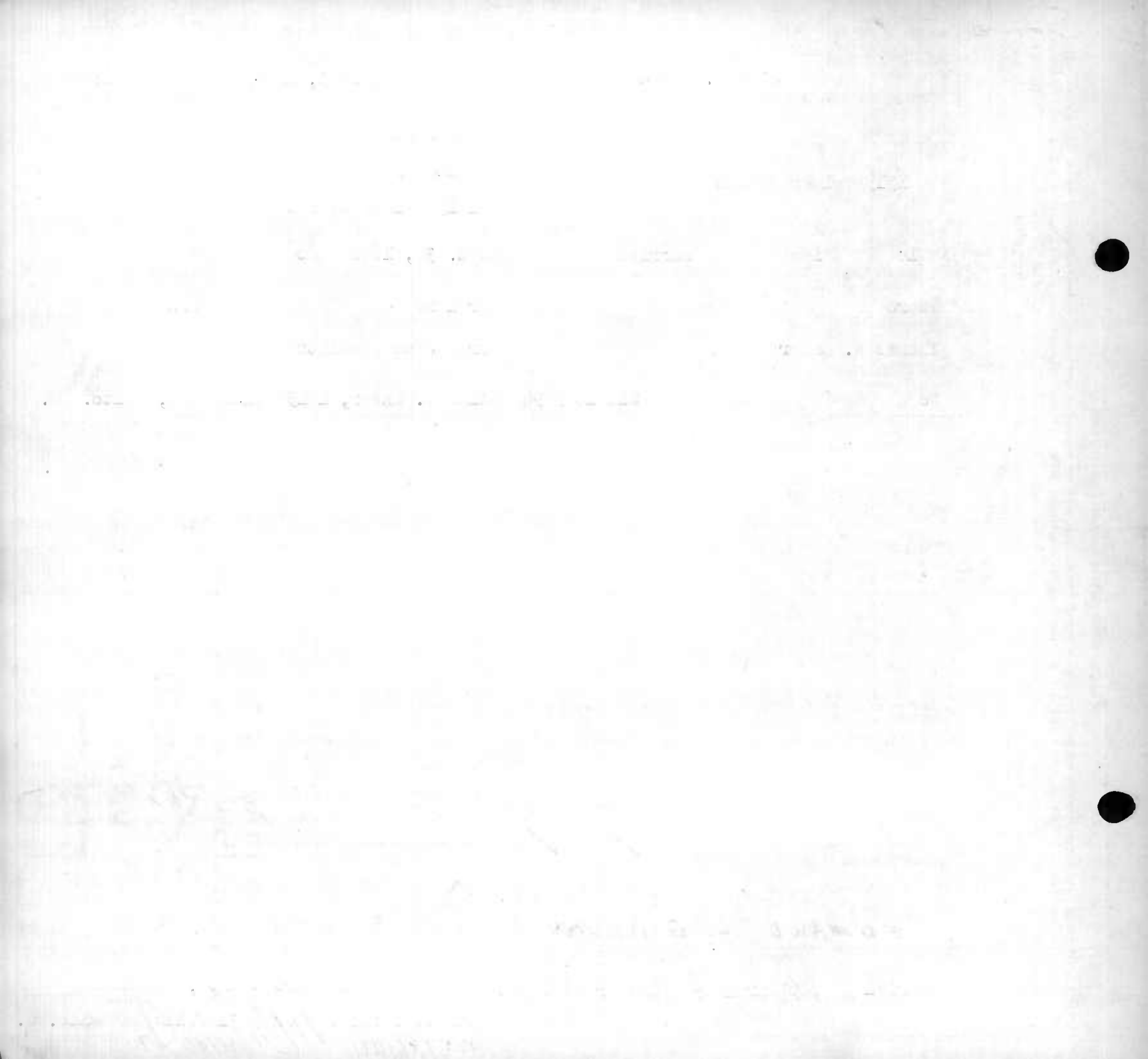
VS 151-REV. 1/1/65



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2511		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2511	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN T. ENSOR		2. DATE AND HOUR OF DEATH March 3, 1965 1:00 p M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1315 Weldon Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13 08 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1315 Weldon Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept. 30, 1878	9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Thomas K. Ensor		14. MOTHER'S MAIDEN NAME Sarah Jane Baublitz		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 10 9794		17. INFORMANT ADDRESS Lelia G. Ensor, 1315 Weldon Ave, Balto. Md.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INF ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) acute myocardial inf DUE TO (B) arteriosclerotic coronary A.D. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 Hrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 19 65 to 3/3 19 65, that (I) (we) last saw the deceased alive on Dec. 25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward L. Glassman M.D.				23B. DATE SIGNED 3/5/65	
23C. PHYSICIAN'S NAME (Type) EDWARD L. GLASSMAN		23D. ADDRESS 4037 Falls Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6 Mar 1965		24C. NAME of CEMETERY or CREMATORY Pine Grove Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 8 1965			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Burgess Funeral Home 3631 Falls Rd Balto. Md.			



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BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 65 2512		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2512	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>DAVID RAY</b>	
2. DATE AND HOUR PRONOUNCED DEAD		March 3, 1965 1:20 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland B. COUNTY <b>53-00</b>	
Baltimore City Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore MIDDLE RIVER	
D. STREET ADDRESS (If rural, give location)		31 Logernn= Road	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH 11/5/44
9. AGE (In years last birthday) 20	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sp. Pt. Not told</b>		11. BIRTHPLACE (State or foreign country) <b>Portland, Oregon</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Herman Ray</b>	
14. MOTHER'S MAIDEN NAME <b>Freda Robertson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>217-40-3901</b>		17. INFORMANT ADDRESS <b>Parents (Same as above)</b>	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
(A) DUE TO <b>Cranio-cerebral injuries</b>			
(B) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(C) DUE TO
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
21C. WHERE DID INJURY OCCUR? <b>174 N. of Myrth Ave</b>		<b>53-00</b>	
21D. TIME OF INJURY (APPROX.) 3 3 65 12:44a		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <b>Driver of auto in fixed-object accident</b>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rudiger Breitenacker</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>3-6-65</b>	
23C. NAME OF CEMETERY or CREMATORY <b>Holy Hill Mem. Bur.</b>		23D. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>MAR 8 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>	
24C. FUNERAL DIRECTOR <b>Connolly</b>		ADDRESS <b>300 Mace Ave. Balto. 21</b>	



VALLEY ROAD

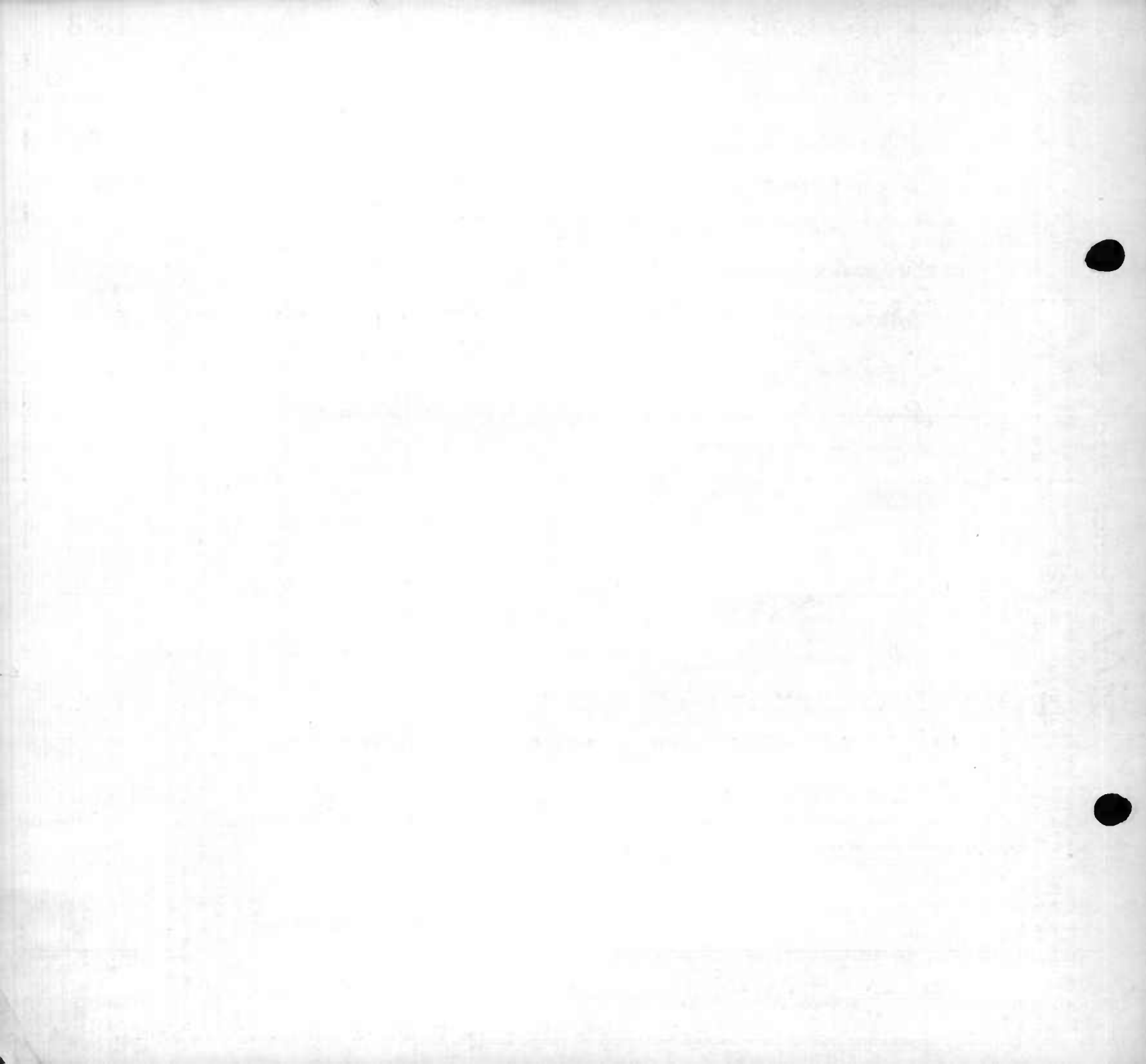
CHANDLER

Robert L.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2513		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2513	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Jesse Bard</i>		2. DATE AND HOUR OF DEATH <i>March 5, 1965 1:30 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION <i>5624 Chrysler Ave</i>		(If not in hospital or institution, give street address or location)		B. COUNTY <i>Maryland</i>	
		C. CITY OR TOWN <i>Baltimore</i>		(If rural, give township)	
		D. STREET ADDRESS <i>5624 Chrysler Ave</i>		(If rural, give location)	
6. SEX <i>male</i>	7. RACE <i>white</i>	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	9. DATE OF BIRTH <i>June 1, 1912</i>	10. AGE (in years last birthday) <i>52</i>	11. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balta, Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Rubin</i>		14. MOTHER'S MAIDEN NAME <i>Fannie</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-103-224</i>		17. INFORMANT <i>Rose Bard</i>	
18. <i>420.1 I</i>		CAUSE OF DEATH		ADDRESS <i>5624 Chrysler Avenue</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <i>Acute myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) <i>Arteriosclerotic cardiovascular disease</i>		<i>5 years</i>	
ANTECEDENT CAUSES		(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1961</i> to <i>March 5 1965</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>March 2 19 65</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Seymour H. Rubin</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>March 5, 1965</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>5415 Park Heights Ave.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/5/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Rosedale</i>	
24D. LOCATION <i>Balta</i>		(City, town, or county)		(State) <i>Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 8 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>Seymour H. Rubin</i>	
25D. ADDRESS <i>3319 Olympia Ave</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BIRTH NO. 65 2514		CERTIFICATE OF DEATH		Registered No. 65 2514	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>ELVIRA Julia McNutt Botts</b>		2. DATE AND HOUR OF DEATH <b>3-3-65</b>		6 <sup>15</sup> / <sub>4</sub> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Harford</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Belair</b>		D. STREET ADDRESS (If rural, give location) <b>Rt. 3, Box 45 (Conowingo Road)</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>				5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		8. DATE OF BIRTH <b>10/14/95</b>		9. AGE (In years lost birthday) <b>69</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Roscoe C. McNutt</b>		14. MOTHER'S MAIDEN NAME <b>ELVIRA JONES</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-28-7678</b>		17. INFORMANT ADDRESS <b>chart - Union Memorial Hospital</b>			
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>Malnutrition</b>				CAUSE OF DEATH (A) DUE TO <b>arteriosclerosis, generalized</b> (B) DUE TO <b>severe of coronary arteries</b> (C) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b></b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b></b>		21C. WHERE DID INJURY OCCUR? <b></b>		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <b></b>		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b></b>					
22. I certify that <del>(it)</del> (this hospital) attended the deceased from <b>2-15</b> 19 <b>65</b> to <b>3-3</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3-3</b> 19 <b>65</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(We)</del> (We) (did not) view the body after death.									
23A. SIGNATURE <b>Lawrence J. Lieberman</b>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-3-65</b>	
23C. PHYSICIAN'S NAME (Type) <b></b>		23D. ADDRESS <b></b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>March 5, 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Southern Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Dublin, Harford Co., Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 8 1965</b>		25B. NAME OF REGISTRAR <b>Roberta E. Staley</b>		25C. FUNERAL DIRECTOR <b>John W. Fink</b>		ADDRESS <b>W. 3000 W. 1st St. Baltimore, Md.</b>			

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 2515 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2515

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JAMES WILLIAM KNISLEY 2. DATE AND HOUR PRONOUNCED DEAD 2-28-65 11:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST. AGNES HOSPITAL -- DOA

A. STATE Maryland B. COUNTY Howard

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Jessup 63-00

D. STREET ADDRESS (If rural, give location)

Guilford Road

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married 8. DATE OF BIRTH April 28 1917 9. AGE (In years last birthday) 47

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer 11. BIRTHPLACE (State or foreign country) Baltimore Md 12. CITIZEN OF WHAT COUNTRY? US A

13. FATHER'S NAME James T. Knisley 14. MOTHER'S MAIDEN NAME Nellie Rang

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. 17. INFORMANT Ever Knisley

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

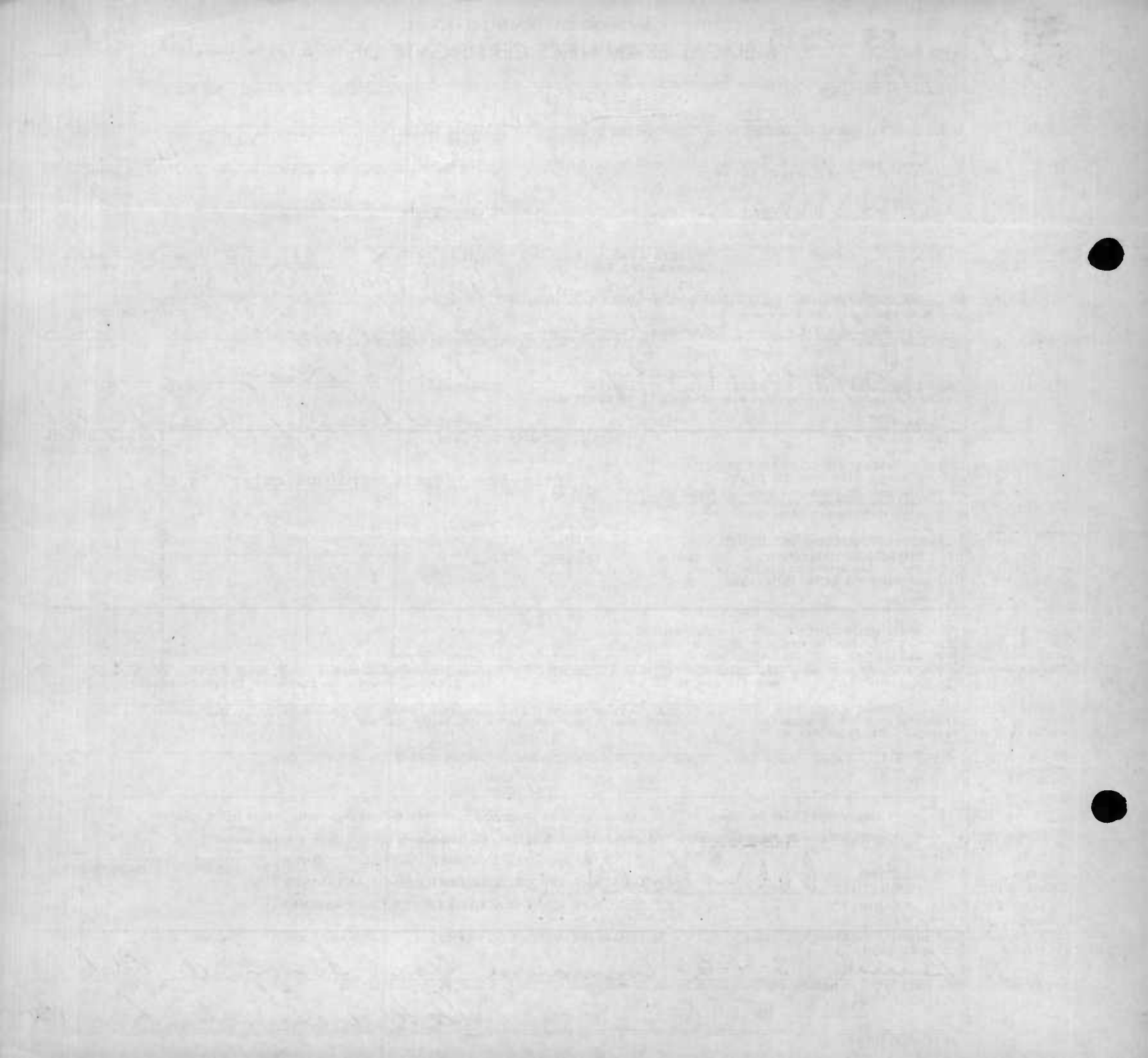
ACTUAL SIGNATURE Peter W. Rieckert M.D. CHIEF MEDICAL EXAMINER DATE SIGNED 3-1-65

EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 3-4-65 23C. NAME of CEMETERY or CREMATORY Emmanuel Am 23D. LOCATION (City, town, or county) (State) Scaggville Md

24A. DATE REC'D BY HEALTH DEPT. MAR 8 1965 24B. NAME OF REGISTRAR Robert E. Fisher M.D. 24C. FUNERAL DIRECTOR 24D. ADDRESS

VS 151-REV. 1/1/65

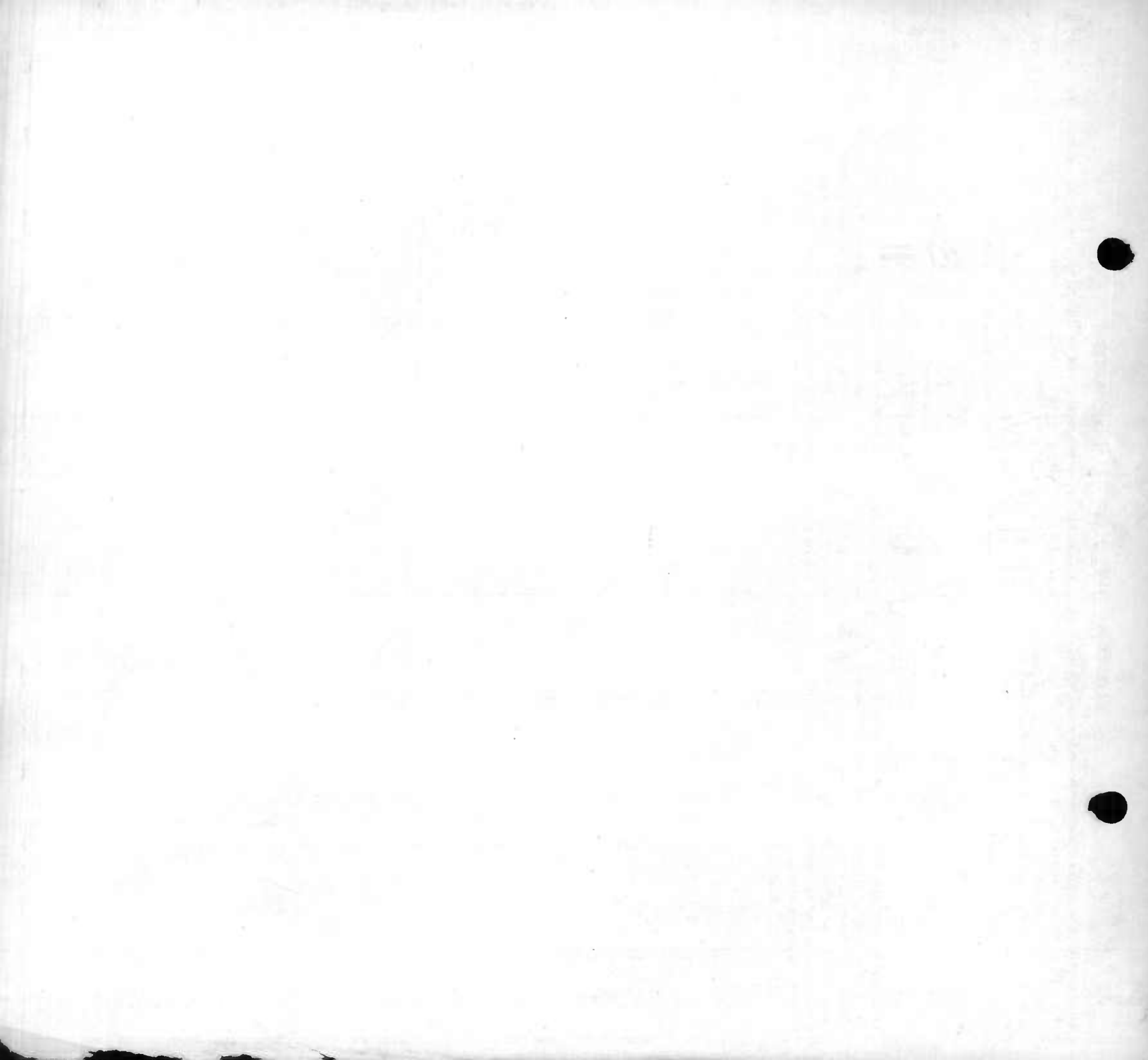




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2516				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2516	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>JACOB DOWNING</u>				2. DATE AND HOUR OF DEATH <u>3/7/65</u> <u>12<sup>25</sup></u> <u>A</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>MARYLAND</u> - <u>16-01</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Med. Gen'l. Hosp.</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>720 N. FREMONT</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W</u>	8. DATE OF BIRTH <u>3-6-84</u>	9. AGE (In years lost birthday) <u>80</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>SAM DOWNING</u>				14. MOTHER'S MAIDEN NAME <u>ELIZIA WATERS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>HOSPITAL CHART</u>	
18. <u>502.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>PNEUMONIA</u> DUE TO (B) <u>Chronic Bronchitis &amp; Emphysema</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hypertensive Cardiovascular Disease</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>we</u> (this hospital) attended the deceased from <u>3/5</u> 19 <u>65</u> to <u>3/7</u> 19 <u>65</u> , that (I) <u>we</u> lost saw the deceased alive on <u>3/7</u> 19 <u>65</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>Gerald A. Wilson</u>				23B. DATE SIGNED <u>3/7/65</u>			
23C. PHYSICIAN'S NAME (Type) <u>Gerald A. Wilson</u>				23D. ADDRESS <u>Med. Gen'l. Hosp. Balto. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-9-1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Int. Oakwood Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1965</u>		25B. NAME OF REGISTRAR <u>G. A. Wilson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>G. A. Wilson</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

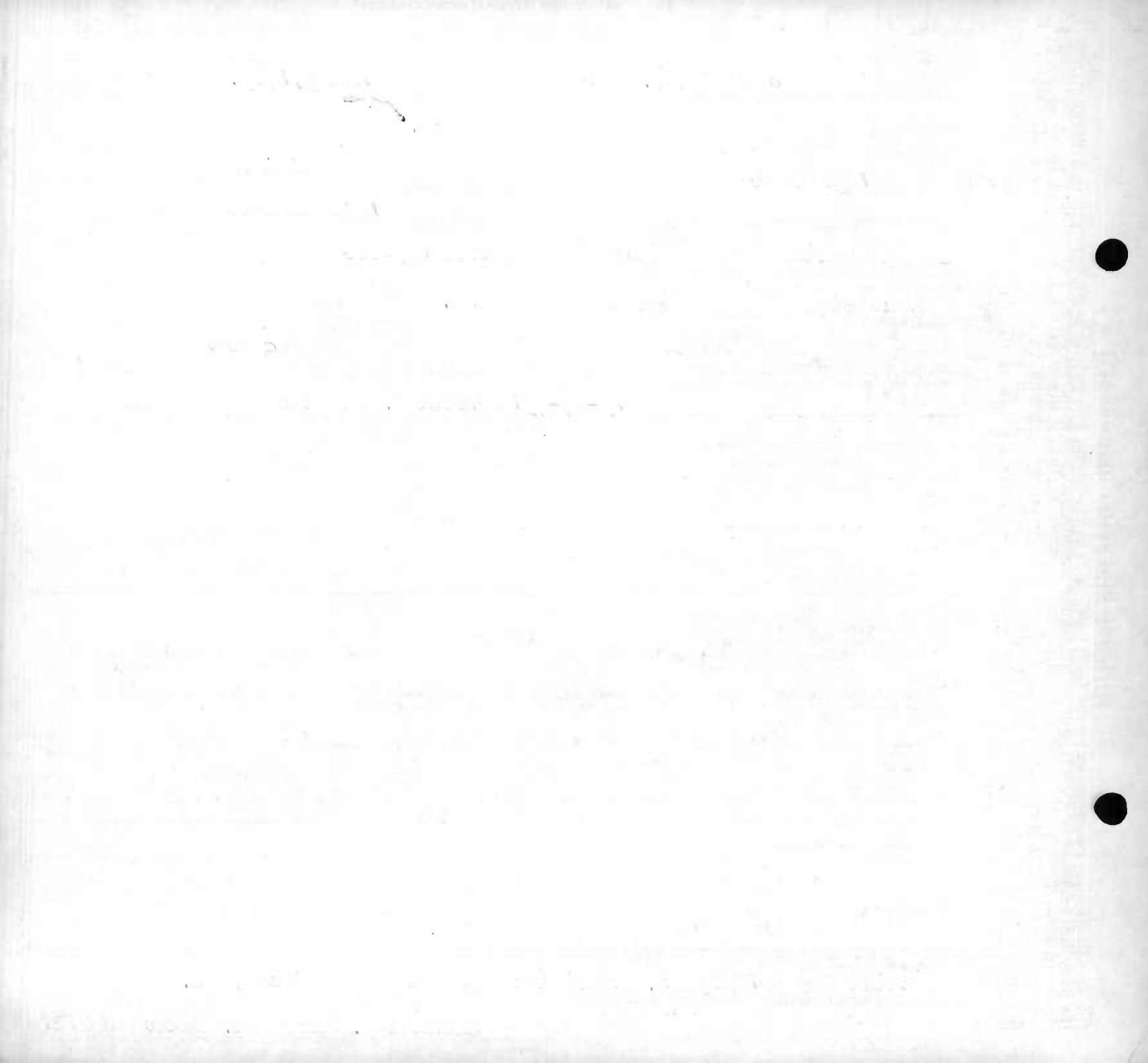
BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 65 2517					CERTIFICATE OF DEATH					Registered No. 65 2517						
1. NAME OF DECEASED (Type or Print) <i>Campbell, Preston</i>										2. DATE AND HOUR OF DEATH <i>3/5/65 @ 1:30</i>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hosp</i>										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>						
										D. STREET ADDRESS (If rural, give location) <i>1828 Ashland Ave</i>						
5. SEX <i>M</i>		6. RACE <i>C</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>		8. DATE OF BIRTH <i>11/17/93</i>		9. AGE (In years last birthday) <i>71</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chemical Pressing Oper.</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>BALTO. Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>PRESTON CAMPBELL, JR.</i>										14. MOTHER'S MAIDEN NAME <i>Unknown</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mary Campbell</i>			ADDRESS <i>SAME</i>						
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>422-141-260X</i>										CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(A) <i>Aspiration Pneumonitis</i>					<i>2 days</i>	
										(B) <i>Organic Brain Syndrome</i>					<i>10 yrs</i>	
										(C) <i>Arteriosclerotic CVD</i>					<i>30 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										<i>Diabetes Mellitus</i>					<i>12 yrs.</i>	
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <i>No</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?						
22. I certify that <i>M</i> (this hospital) attended the deceased from <i>3/11</i> 19 <i>65</i> to <i>3/5</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>3/5</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>12 N</i>																
23A. SIGNATURE <i>Virgil Brown</i>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/5/65</i>				
23C. PHYSICIAN'S NAME (Type), <i>Virgil Brown</i>										23D. ADDRESS M.D.						
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>3/9/1965</i>		24C. NAME of CEMETERY or CREMATORY <i>Arbutus Cml</i>					24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>						
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 8 1965</i>					25B. NAME OF REGISTRAR <i>Robert E. Farber</i>					25C. FUNERAL DIRECTOR <i>Chas. W. Brown</i>						
										ADDRESS						



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2518				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2518	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Josephine T. Mroczka</i>				2. DATE AND HOUR OF DEATH <i>March 7, 1965.</i> <i>7 00</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1638 Lochwood Road</i>				A. STATE <i>Md.</i> B. COUNTY <i>27-09</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>1638 Lochwood Road</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>March 19, 1888</i>	9. AGE (In years last birthday) <i>76</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Unk.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jacob Kramer</i>				14. MOTHER'S MAIDEN NAME <i>Ida Modrak</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-09-4512</i>		17. INFORMANT <i>Helen M. Pezzica</i>		ADDRESS <i>Same</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Metastatic Carcinoma of the Breast</i>				CAUSE OF DEATH (A) DUE TO <i>Failure</i> (B) DUE TO <i>Complication of Kidney</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i> <i>1 yr</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Anemia</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Dec 1963</i> to <i>Mar 7 1965</i> that (I) (we) last saw the deceased alive on <i>Mar 7 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Dr. Paul Byrd</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3/8/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Paul Byrd</i>				23D. ADDRESS <i>5620 1/2 H St Rd Balto Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/10/65</i>		24C. NAME of CEMETERY or CREMATORY <i>St. Stanislaus Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 8 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>		ADDRESS <i>Balto Md 21214</i>	

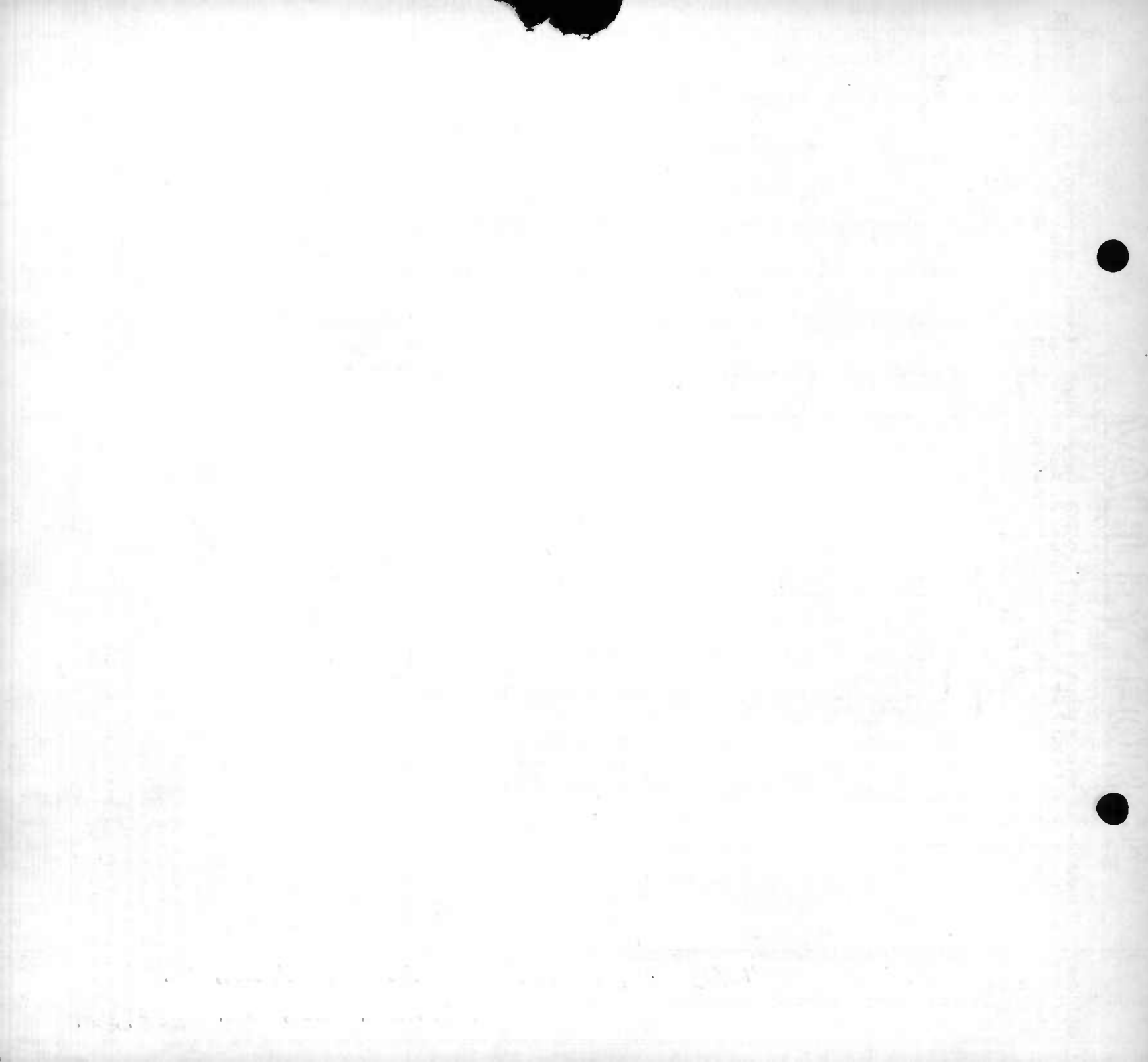


# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		65 2519		HEALTH DEPARTMENT		Registered No. 65 2519	
1. NAME OF DECEASED (Type or Print) <i>Mary Catherine Kansler</i>				2. DATE AND HOUR OF DEATH <i>3.7.65</i>   <i>12<sup>50</sup> P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>47 Hospital For the Women of Maryland</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>27-38</i> D. STREET ADDRESS (If rural, give location) <i>1654 Sherwood Ave.</i>			
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, <i>Married</i>	8. DATE OF BIRTH <i>6.8.11</i>	9. AGE (in years lost birthday) <i>53</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Patrick Lennon</i>				14. MOTHER'S MAIDEN NAME <i>MARY Burns</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Hospital Admission Sheet</i>		
18. <i>199.2.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Cachexia + general wasting.</i> (B) <i>Carcinomatosis.</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
19A. DATE OF OPERATION <i>Nov. 1964</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Exploratory Laparotomy for progressive wt. loss &amp; diarrhea</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Feb 24</i> 19 <i>65</i> to <i>March 7</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>March 7</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <del>did not</del> view the body after death.							
23A. SIGNATURE <i>J. K. Chow</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>March 7, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Leslie</i>		23D. ADDRESS M.D. <i>302 - E 33rd St.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/10/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Dulaney Valley Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 8 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto., Md.</i>			





# FUNERAL DIRECTOR: IMPORTANT

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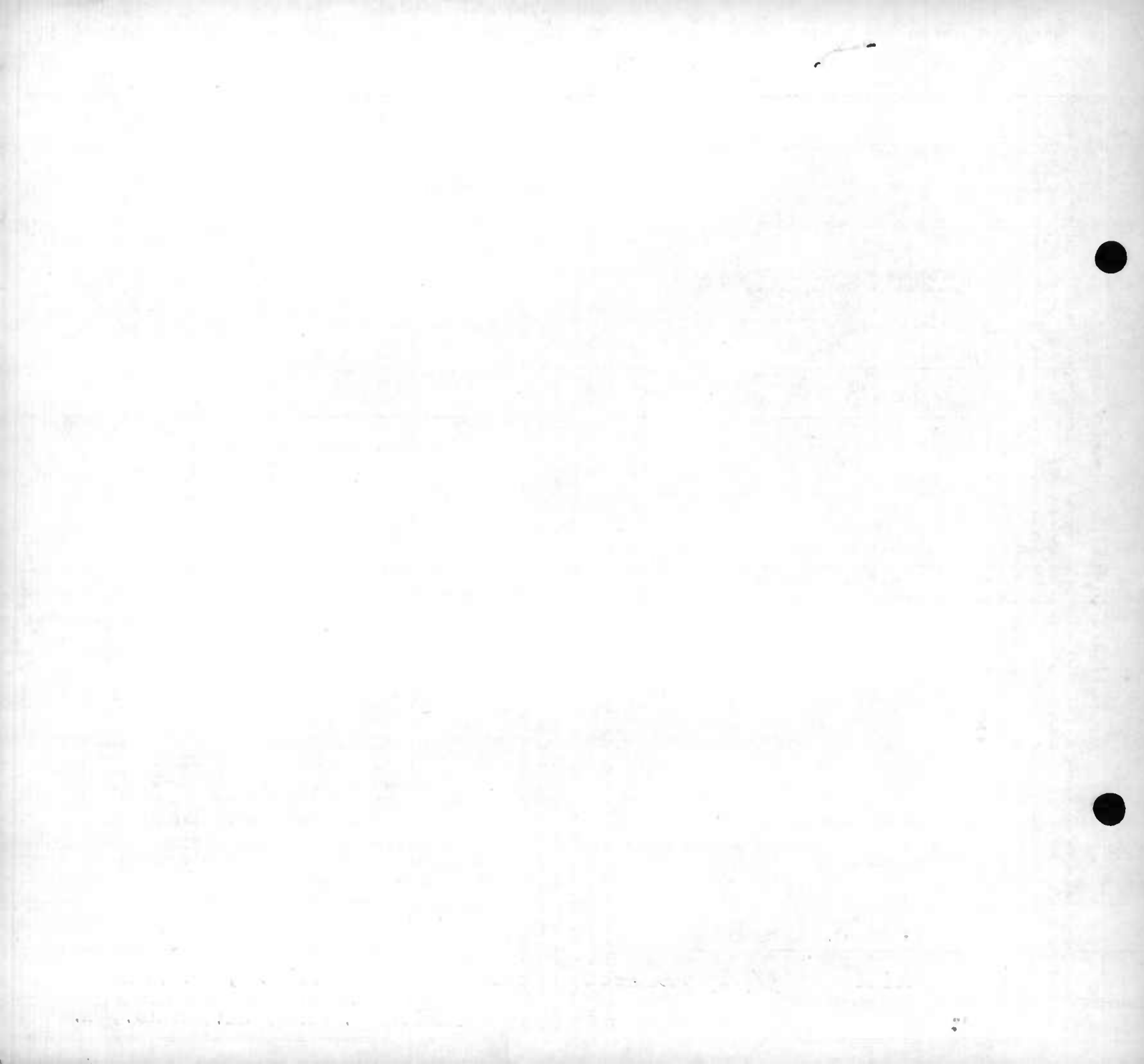
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2520</b>	
BIRTH NO. <b>65 2520</b>		CERTIFICATE OF DEATH	
M.E. CASE NO.		DATE AND HOUR OF DEATH <b>3-6-65 1:50 P.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>Mrs Charlotte Hill</b>		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>md</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Bon Secours Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore Md. #6 53-00</b>	
5. SEX <b>F</b> 6. RACE <b>W</b>		D. STREET ADDRESS (If rural, give location) <b>1900 Weybern Rd Balto 6</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>5/14/84</b> 9. AGE (In years last birthday) <b>80</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>V.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Turner</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>190-14-8097B</b>	
17. INFORMANT <b>Elizabeth Miller</b>		ADDRESS <b>Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebral arteriosclerosis years.</b>		DUE TO <b>Generalized arteriosclerosis years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Terminal Bronchopneumonia</b>		DUE TO <b>Days</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Feb. 28 12 mid 1965</b> to <b>March 6 1965</b> , that (I) (we) last saw the deceased alive on <b>March 6 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Agustin del Campo</b> M.D.		23B. DATE SIGNED <b>3-6-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>AGUSTIN DEL CAMPO</b> M.D.		23D. ADDRESS <b>Bon Secours Hosp. Baltimore Ind</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/9/65</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 8 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltner</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>Balto Md 21214</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2521	
BIRTH NO. 65 2521		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MARTHA MAUER (Mayer)		2. DATE AND HOUR OF DEATH MARCH 6, 1965 9:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSP.		A. STATE MARYLAND B. COUNTY BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 6 S. MONASTERY ST.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 11/25/92	9. AGE (In years lost birthday) 72	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Not known			16. SOCIAL SECURITY NO.	17. INFORMANT CITAS. JENSON, Jr. (son)	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO Arteriosclerosis Heart Disease? Rheumatic Heart Disease?		± 20 yr	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Old Auto Vm. Accident?		± 5 yr	
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb. 14 1961 to March 6 1965, that (I) (we) last saw the deceased alive on MARCH 6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Reuben C. Guerrero M.D.			23B. DATE SIGNED 3/6/65		
23C. PHYSICIAN'S NAME (Type) REUBEN C. GUERRERO			23D. ADDRESS Montebello State Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/9/65	24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. MAR 8 1965	25B. NAME OF REGISTRAR Robert E. Fisher	25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., Balto., Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2522		CERTIFICATE OF DEATH		Registered No. 65 2522	
1. NAME OF DECEASED (Type or Print) <b>FLORENCE FORRESTER</b>				2. DATE AND HOUR OF DEATH <b>March 5, 1965</b> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>5685 Belair Rd.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2601</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>5685 Belair Rd. #6</b>					
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>		8. DATE OF BIRTH <b>1/27/1888</b>		9. AGE (In years last birthday) <b>77</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>August M. Frey</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Young</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Mary Rebbel 5685 Belair Rd. #6</b>			
18. <b>422.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Hypostatic pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Myocarditis Grade IV</b> <b>Chronic gastritis - mucosa prolapse</b> <b>Splenomegaly</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>April 1945</b> to <b>March 5, 1965</b> , that (I) <del>was</del> last saw the deceased alive on <b>March 3, 1965</b> and that in (my) <del>was</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.									
23A. SIGNATURE <b>H.V. Harbold</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>March 6, 1965</b>			
23C. PHYSICIAN'S NAME (Type) <b>H.V. HARBOLD</b>				23D. ADDRESS <b>4706 Harford Road - 14</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/9/65</b>		24C. NAME of CEMETERY or CREMATORY <b>HOLY REDEEMER CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Rd.</b>			

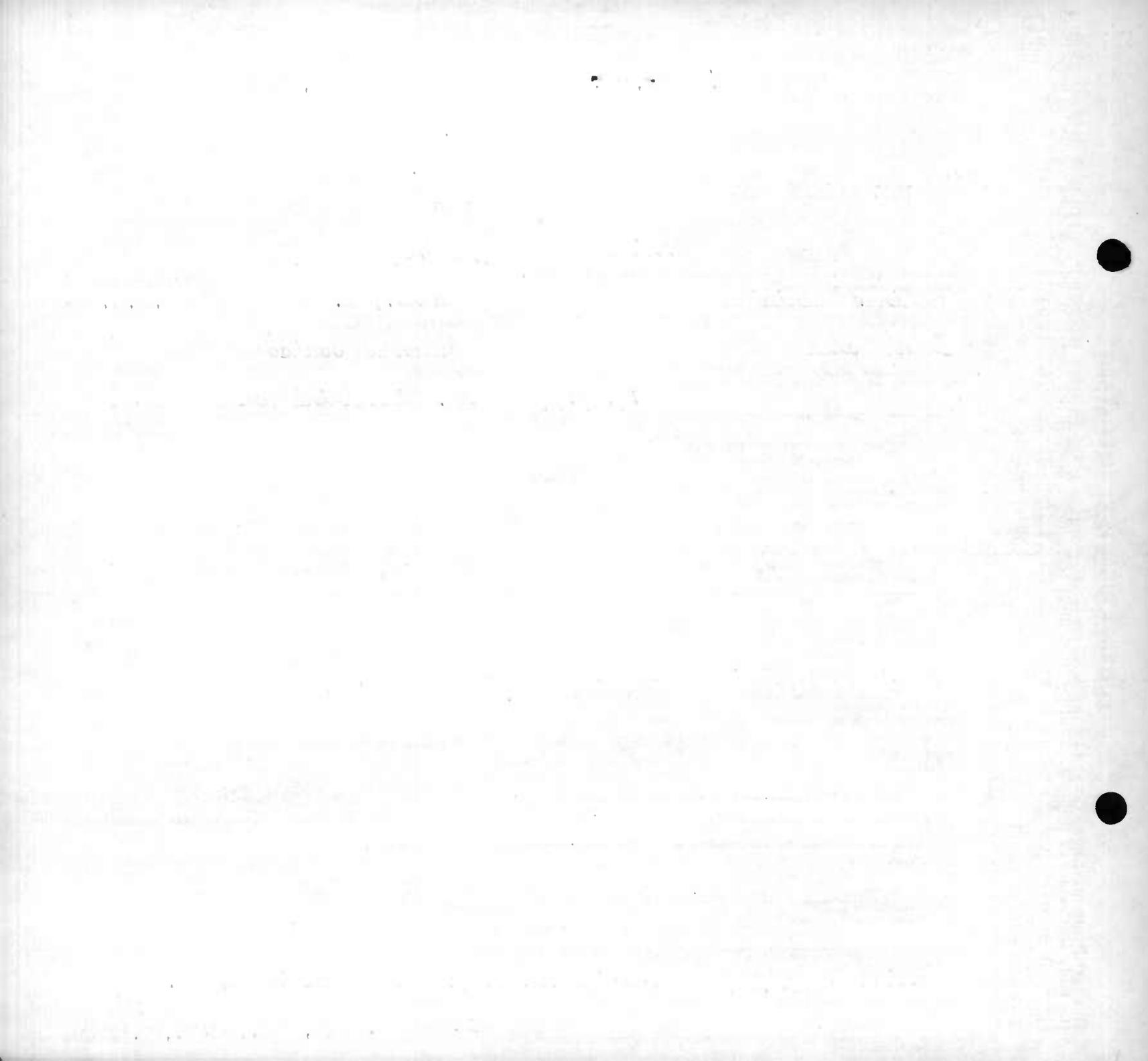




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

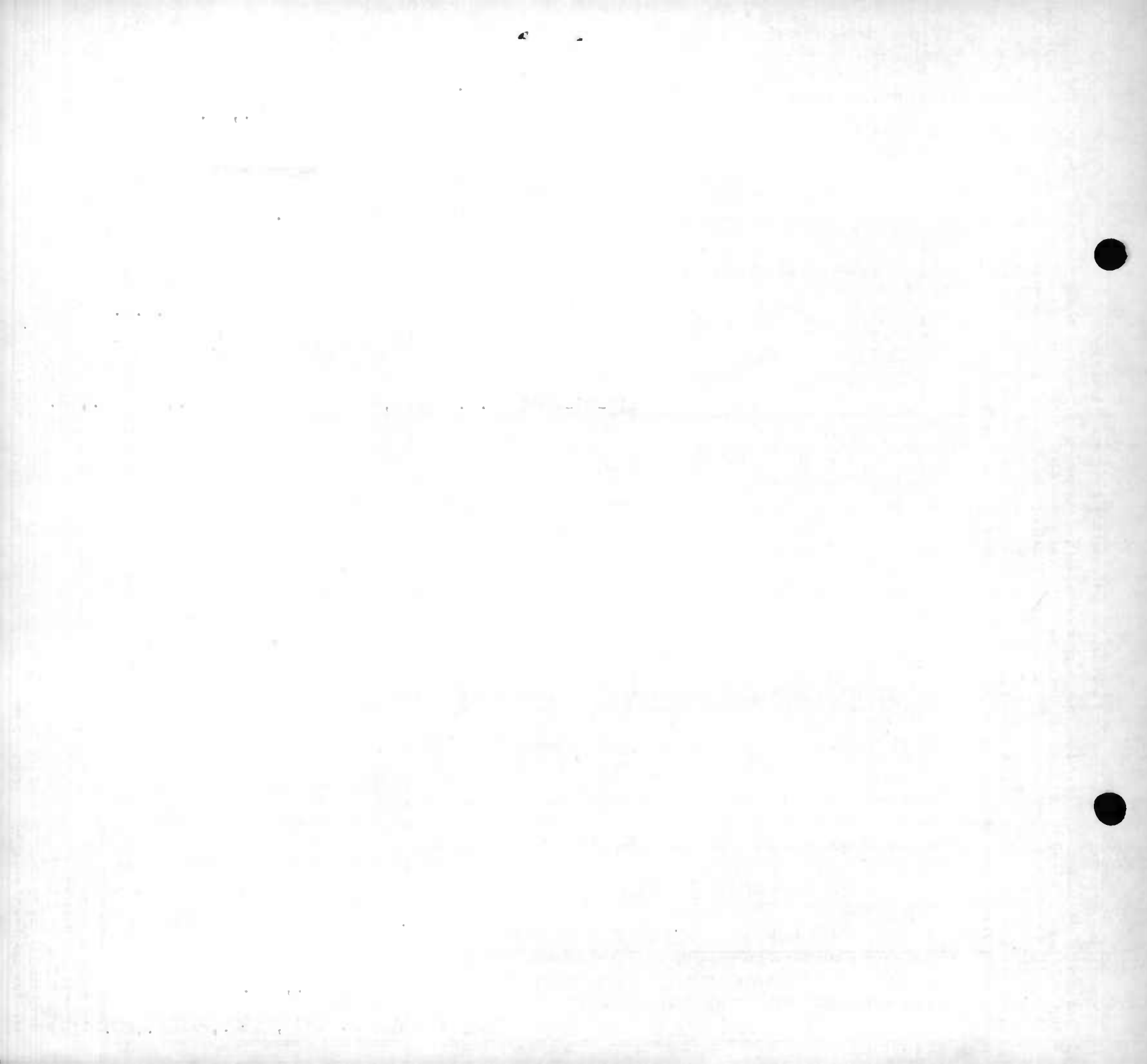
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2523		CERTIFICATE OF DEATH		Registered No. 65 2523	
1. NAME OF DECEASED (Type or Print) <b>LAWRENCE VOTTA, SR.</b>				2. DATE AND HOUR OF DEATH <b>MARCH 5, 1965</b> 3:05 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1401 KITMORE ROAD</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>27-09</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b> D. STREET ADDRESS (If rural, give location) <b>1401 KITMORE ROAD</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>9/22/1892</b>		9. AGE (In years, last birthday) <b>72</b>		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <b>Retired Machinist</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Frank Votta</b>				14. MOTHER'S MAIDEN NAME <b>Susanna Coonico</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>214163159</b>		17. INFORMANT <b>Mrs. Wilhelmina Votta</b>		ADDRESS <b>Same</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>153.8 I</b>				CAUSE OF DEATH (A) <b>Adenocarcinoma Colon</b> DUE TO (B) <b>Metastasis to Bladder,</b> DUE TO (C) <b>Small intestine, Liver, pancreas, Colon,</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> <b>1 year</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>Oct 28, 1964</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal obstruction</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the hospital) attended the deceased from <b>Feb 26</b> 19 <b>64</b> to <b>Mar 5</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>March 5</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>S. G. Sullivan</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3-6-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>S. G. Sullivan</b>				23D. ADDRESS M.D. <b>1129 St Paul St Baltimore 2, Md</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/9/65</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Sullivan</b>		25C. FUNERAL DIRECTOR <b>LEONARD J. RUCK, INC., BALTO., MD. 21214</b>					



# FUNERAL DIRECTOR: IMPORTANT

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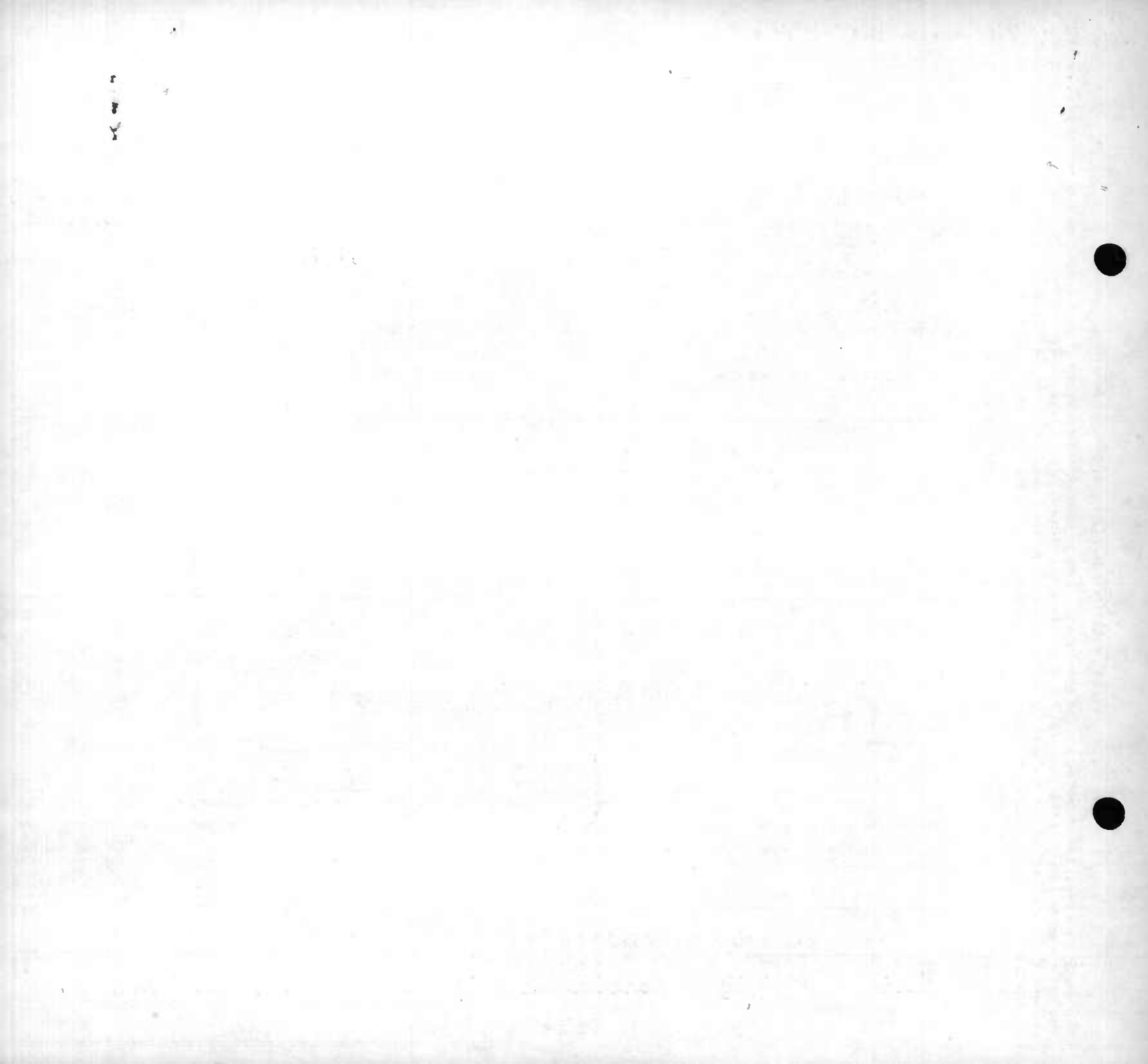
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 2524					CERTIFICATE OF DEATH X Registered No. 65 2524				
M.E. CASE NO.					2. DATE AND HOUR OF DEATH 3-5-65 10:30 P.M.				
1. NAME OF DECEASED (Type or Print) WAITZ, Elizabeth H. K.					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					A. STATE BALTO., MD.				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					B. COUNTY BALTO., MD.				
Bel Aire House in the Pines					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. 53-00				
					D. STREET ADDRESS (If rural, give location) 3024 WOODSIDE AVE.				
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED (specify))		8. DATE OF BIRTH 10-19-80		9. AGE (In years last birthday) 84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES HAEGERICHS					14. MOTHER'S MAIDEN NAME MARQUARD				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 213-03-2805		17. INFORMANT C.B. WAITZ, 3024 WOODSIDE AVE., BALTO., MD.		
18. 4-93X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH PNEUMONIA				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 3-26 1969 to 3/5 1965, that (I) (we) last saw the deceased alive on 3/5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Marcos Levin M.D.					23B. DATE SIGNED 3-5-65				
23C. PHYSICIAN'S NAME (Type) MARCOS LEVIN M.D.					23D. ADDRESS 201 Wise Ave Balto 22				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/9/65		24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO., MD.			
25A. DATE REC'D BY HEALTH DEPT. MAR 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR ADDRESS 2 LEONARD J. RUCK, INC., BALTO., MD. 21214				



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 2525					CERTIFICATE OF DEATH					Registered No. 65 2525									
M.E. CASE NO.										2. DATE AND HOUR OF DEATH									
1. NAME OF DECEASED (Type or Print) RUTH G. NICELY										March 6, 1965 1 808 P. M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS										A. STATE B. COUNTY Maryland Baltimore									
(If not in hospital or institution, give street address or location)										C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 5300									
										D. STREET ADDRESS (If rural, give location) Rout 14 Box 515 Seneca Park, Maryland									
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH November 17, 1917		9. AGE (In years last birthday) 47		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CASHIER/CLERK					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Baltimore, Md.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME THOMAS WALTER GEMMILL										14. MOTHER'S MAIDEN NAME MARY EDNA EARL									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT MARY WHEATLEY					ADDRESS Same				
18. 214X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) Pneumonia. Heart failure										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH days				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.																			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Vaginal Hysterectomy																			
19A. DATE OF OPERATION February 17, 1965					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fibroid Uterus. Cystocele					20A. AUTOPSY? (Yes or No) No					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from February 16 1965 to March 6 1965, that (I) (we) last saw the deceased alive on March 6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Antonio Galindo										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED March 6, 1965				
23C. PHYSICIAN'S NAME (Type) ANTONIO GALINDO										M.D. ADDRESS BON SECOURS HOSPITAL									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 3/9/65					24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park Cemetery, Baltimore, Md.					24D. LOCATION (City, town, or county) (State)				
25A. DATE REC'D BY HEALTH DEPT. MAR 9 1965					25B. NAME OF REGISTRAR Robert E. Taylor, M.D.					25C. FUNERAL DIRECTOR Leonard J. Puckett					5305 ADDRESS				

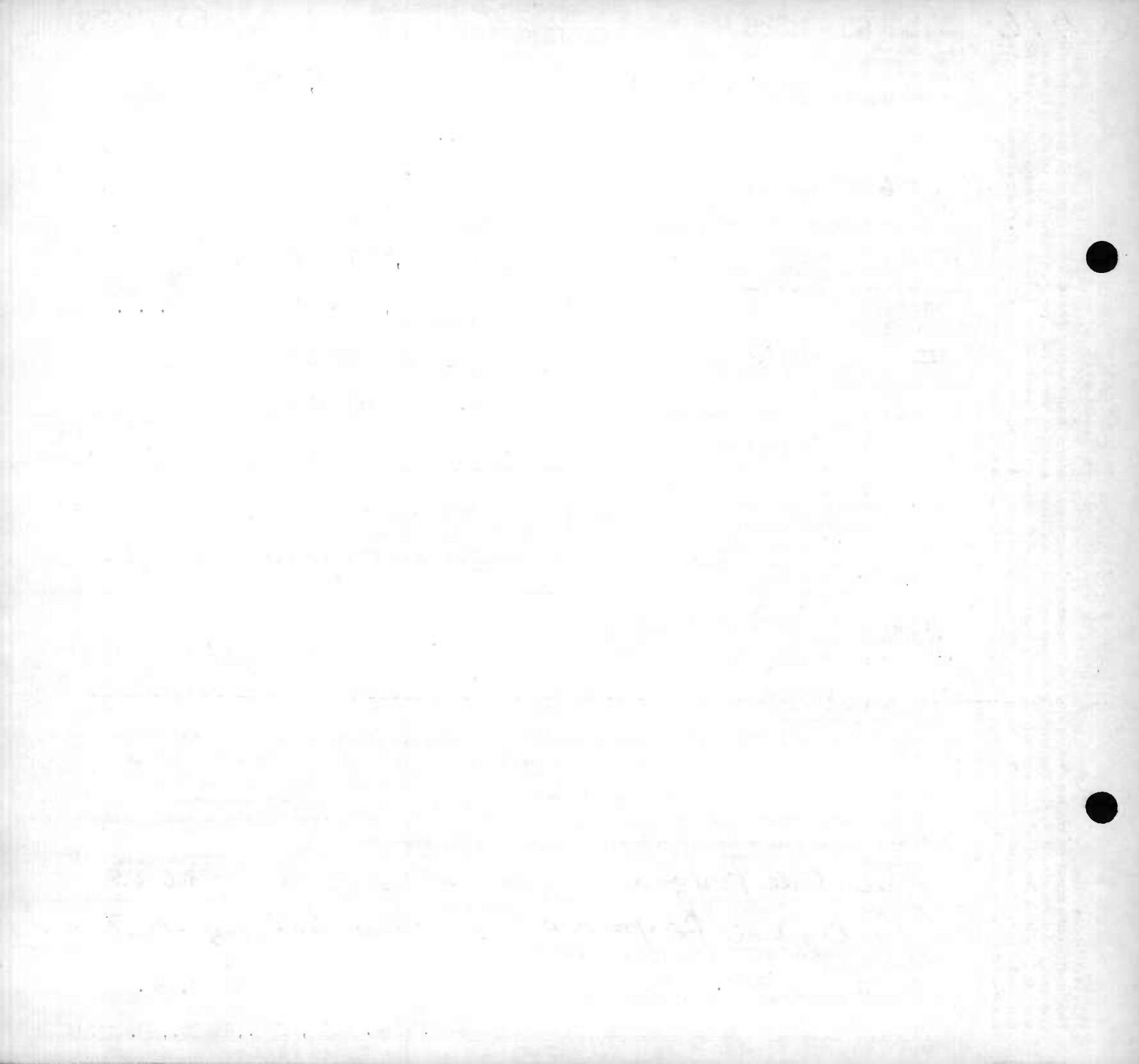


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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 2526</b>	
BIRTH NO. <b>65 2526</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>FANNIE LOUISE COLEBURN</b>		2. DATE AND HOUR OF DEATH <b>MARCH 5, 1965</b>	
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>938 ARMSTEAD WAY</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b>			
		D. STREET ADDRESS (If rural, give location) <b>938 ARMSTEAD WAY</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b>	8. DATE OF BIRTH <b>MARCH 31, 1896</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM LUCAS</b>		14. MOTHER'S MAIDEN NAME <b>KATE WHITLEY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. ALDEN COLEBURN</b>	
				ADDRESS <b>SAME</b>	
18. <b>42011</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b>		CAUSE OF DEATH (A) DUE TO <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>arteriosclerosis</b>		(B) DUE TO <b>arteriosclerosis</b>		<b>years</b>	
		(C) DUE TO		<b>years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert S. de Boya</i> M.D.				23B. DATE SIGNED <b>3-6-65</b>	
23C. PHYSICIAN'S NAME (Type) <i>Robert S. de Boya M.D.</i>				23D. ADDRESS <b>1020 armistead way - Balto md</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/9/65.</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE CEMETERY</b>	
24D. LOCATION <b>BALTIMORE, MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>			
25B. NAME OF REGISTRAR <i>Robert E. Talley</i>		25C. FUNERAL DIRECTOR <b>LEONARD J. RUCK, INC., BALTO., MD. 21214</b>			

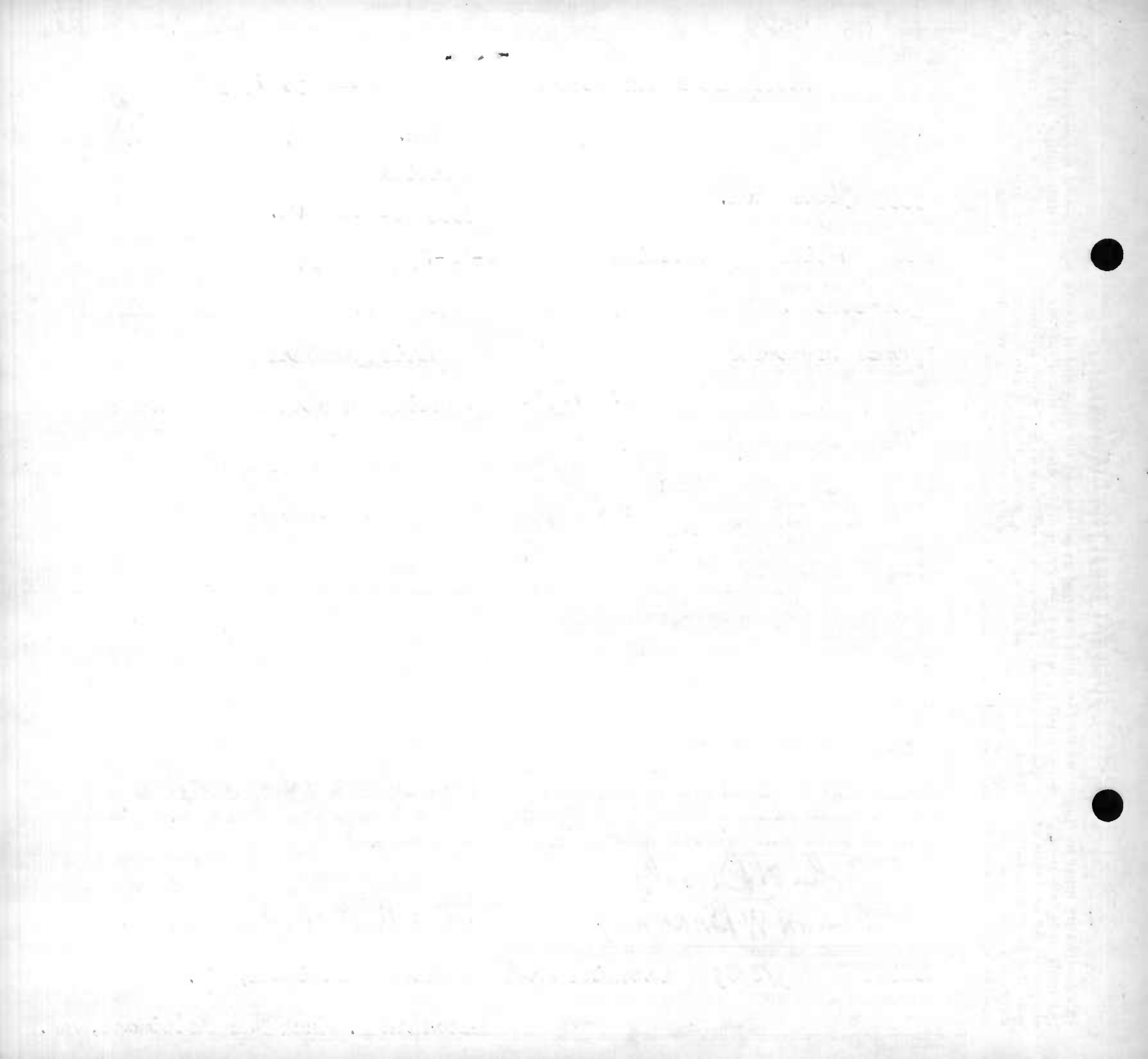




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

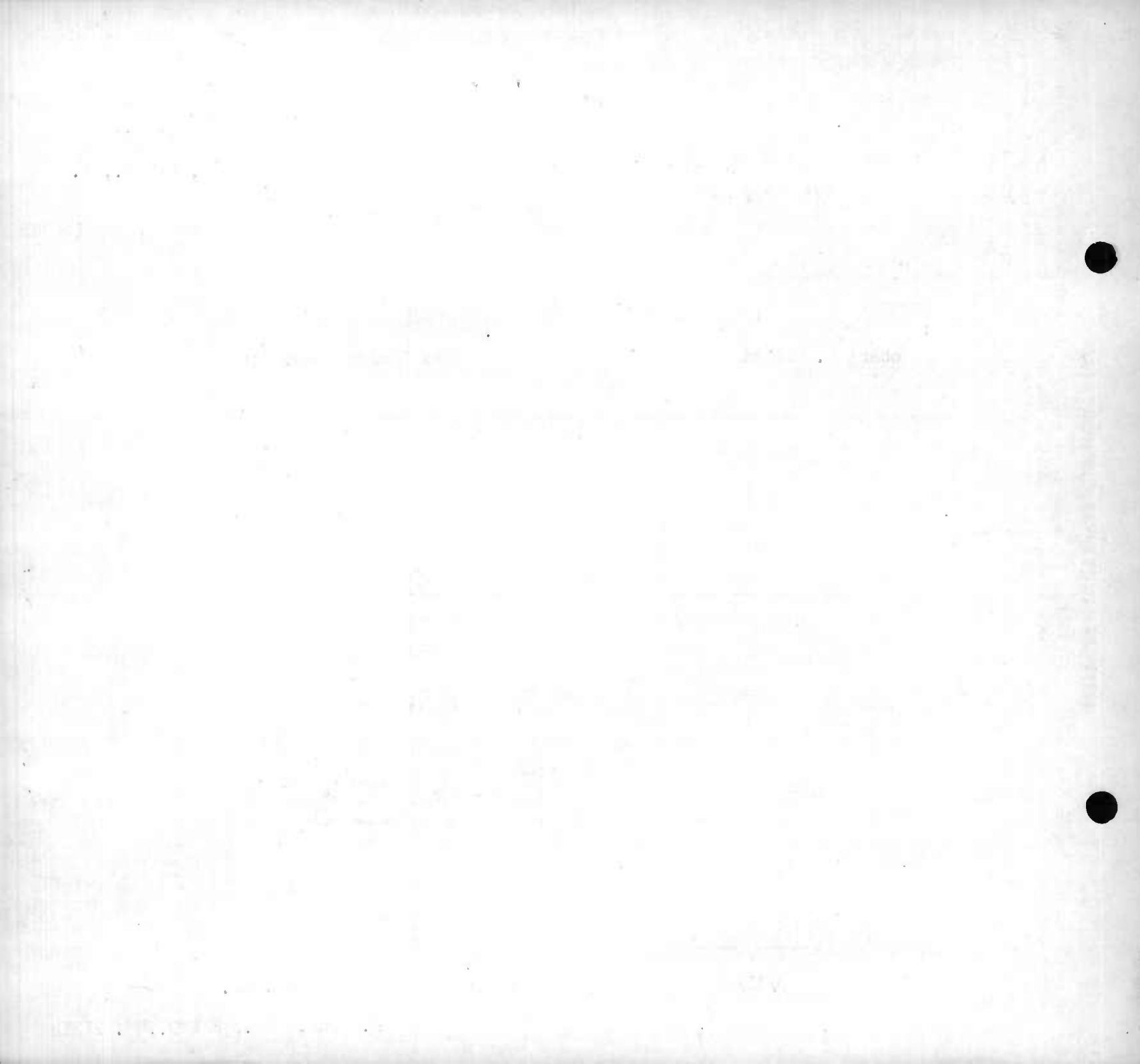
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 2527	
BIRTH NO. 65 2527										M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <i>Harley Leroy Humphreys</i>					2. DATE AND HOUR OF DEATH <i>March 5, 1965</i> 1 3 A.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>26-03</i>						
FULL NAME OF HOSPITAL OR INSTITUTION <i>3553 Elmley Ave.</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>						
(If not in hospital or institution, give street address or location)					D. STREET ADDRESS (If rural, give location) <i>3553 Elmley Ave.</i>						
5. SEX <i>male</i>		6. RACE <i>white</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>		8. DATE OF BIRTH <i>6-26-1905</i>		9. AGE (In years last birthday) <i>59</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>					10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Humphreys</i>					14. MOTHER'S MAIDEN NAME <i>Annie Chambers</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <i>216018428</i>		17. INFORMANT <i>Pauline Humphreys</i>			ADDRESS <i>same</i>	
18. <i>162.1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Bronchogenic carcinoma, right</i> DUE TO (B) <i>multiple skeletal metastases</i> DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH <i>same</i>						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>2</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>Yes</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>19 November 1964</i> to <i>5 March 1965</i> , that (I) (we) lost saw the deceased alive on <i>1 March 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>John W Barnaby</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>5 Mar 65</i>			
23C. PHYSICIAN'S NAME (Type) <i>JOHN W BARNABY</i>					23D. ADDRESS <i>1531 E North Ave Baltimore Md</i>						
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>3/8/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Lorraine Park Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 9 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Gasky, M.D.</i>			25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i>			ADDRESS <i>Baltimore, Md.</i>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

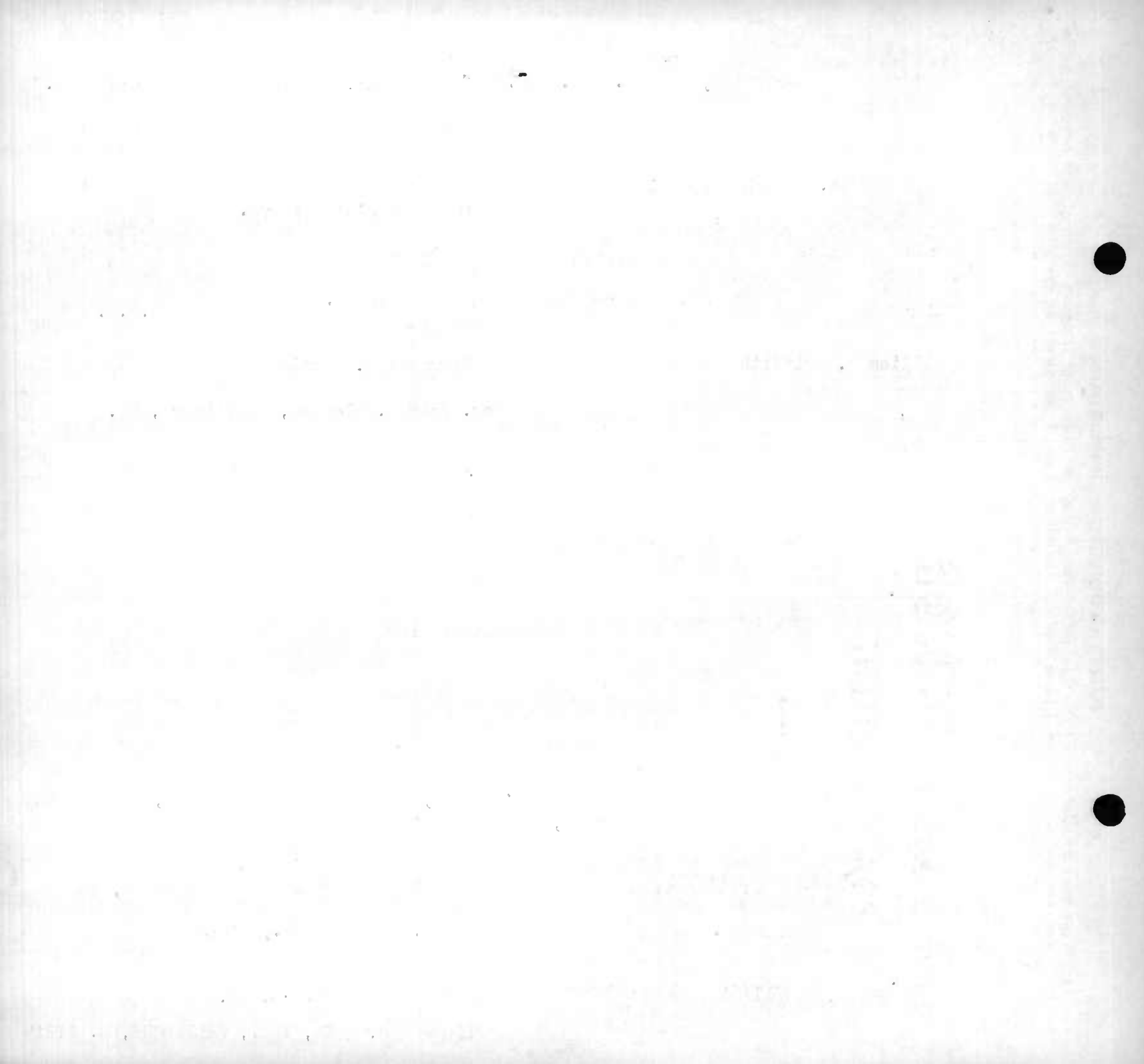
BIRTH NO. 65 2528		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2528	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM B. WRIGHT SR.		2. DATE AND HOUR OF DEATH 3-6-65 11:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY #6		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Balto., Md.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP. OF BALTIMORE MARYLAND		D. STREET ADDRESS (If rural, give location) 1913 Aster Road		5300	
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-29-12	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY WRIGHT Contracting Company -		11. BIRTHPLACE (State or foreign country) ALABAMA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME / Robert H. Wright		14. MOTHER'S MAIDEN NAME Anna Louise Robertson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT WIFE - Ruby Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Adenocarcinoma of the lungs (B) metastasis to various organs (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-6-1965 to 3-6-1965, that (I) (we) last saw the deceased alive on 3-6-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alex P. Yadao		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-7-65	
23C. PHYSICIAN'S NAME (Type) ALEX P. YADAO		23D. ADDRESS Sinai Hosp. of Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/11/65		24C. NAME OF CEMETERY or CREMATORY PARK HILL CEMETERY	
24D. LOCATION COLUMBUS, GA.		24E. DATE REC'D BY HEALTH DEPT. MAR 9 1965		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21211		24H. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2529</u>	
BIRTH NO. <u>65 2529</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Griffith, John C. (Rt. Rev.)</u>		2. DATE AND HOUR OF DEATH <u>March 7, 1965</u>   <u>4:35</u> P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Joseph Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-16</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 21215</u> D. STREET ADDRESS (If rural, give location) <u>4502 Park Heights Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>5/21/1910</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clergyman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>St. Ambrose Church</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William E. Griffith</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret A. Martin</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Rev. John T. Sleeman, Baltimore, Md.</u>			
18. <u>420.14-260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Anterior myocardial infarction with congestive heart failure</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>Anterior myocardial infarction with congestive heart failure</u>			
(B) DUE TO		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Diabetes mellitus</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 4, 19 65</u> to <u>March 7, 19 65</u> , that (I) (we) last saw the deceased alive on <u>March 7, 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Melito M. Torres</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>March 7, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Melito M. Torres</u>		23D. ADDRESS M.D. <u>1400 N. Caroline St., 21213</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3/11/65</u>		24C. NAME of CEMETERY or CREMATORY <u>NEW CATHEDRAL CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>LEONARD J. RUCK, INC., BALTIMORE, MD. 21214</u>	

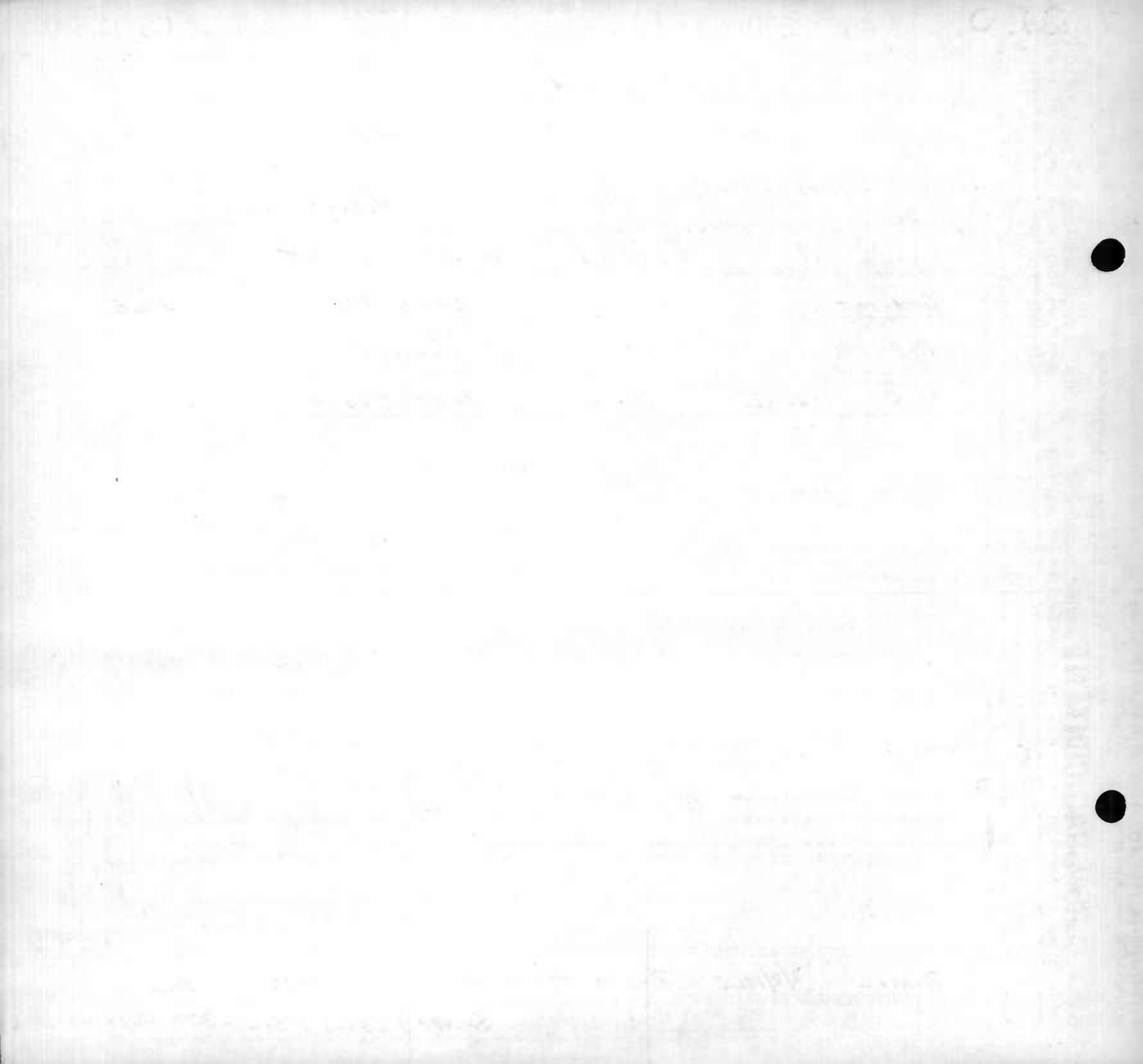




# FUNERAL DIRECTOR: IMPORTANT

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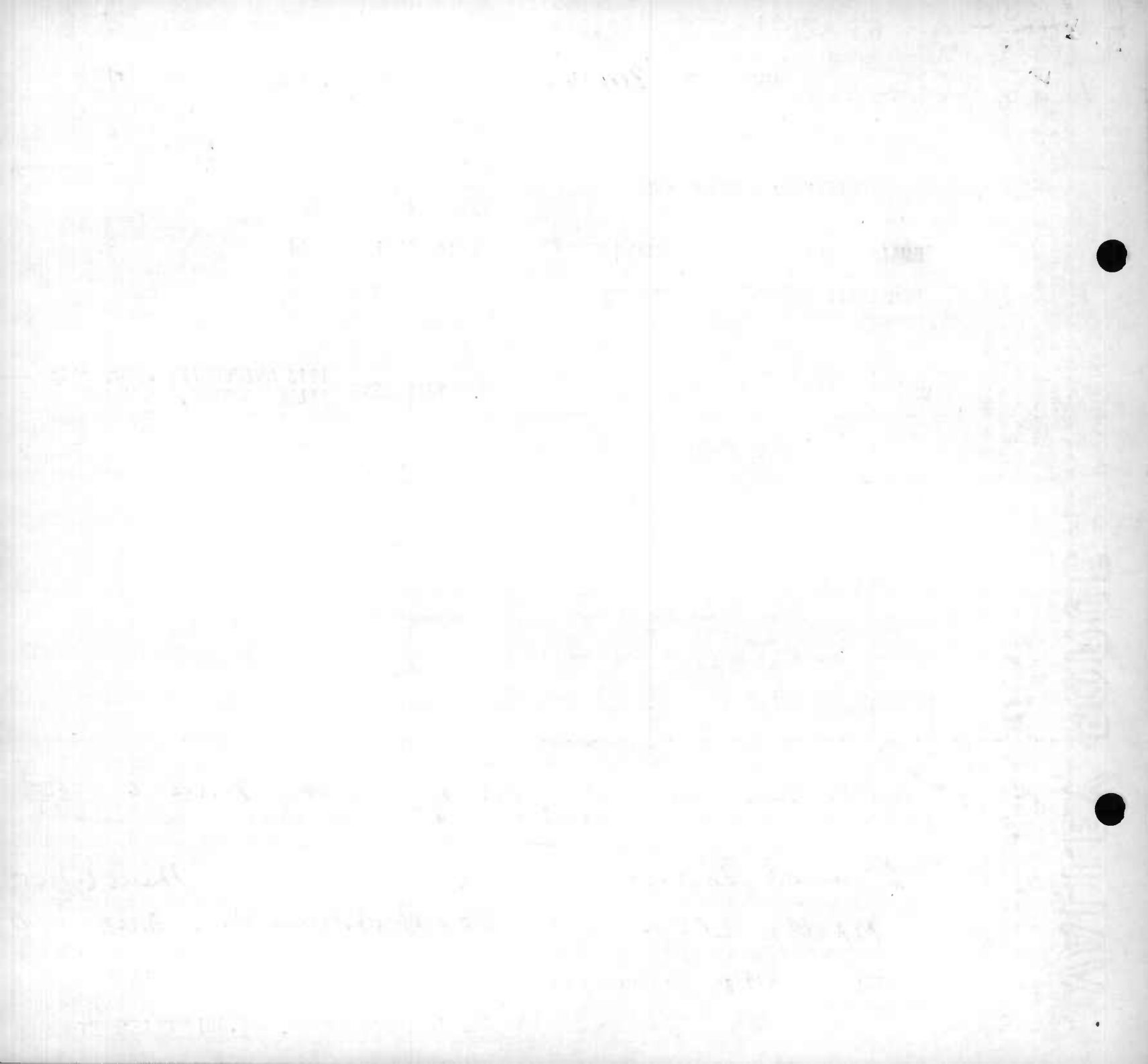
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 2530	
BIRTH NO. 65 2530		CERTIFICATE OF DEATH									
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Samuel Reisig						2. DATE AND HOUR OF DEATH 3/5/65 12 <sup>20</sup> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-12									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospt		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE									
		D. STREET ADDRESS (If rural, give location) 2616 VIOLET AVE									
5. SEX m.	6. RACE w	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10-28-1896	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO. MD		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME MEYER				14. MOTHER'S MAIDEN NAME PAULINE							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WAR I		16. SOCIAL SECURITY NO. 220-36-4086		17. INFORMANT Hospt Chgr		ADDRESS					
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Arteriosclerotic Cardiovascular disease with left middle cerebral artery thrombosis (B) DUE TO (C)						INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. pneumonia											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 3/2 1965 to 3/5 1965, that (I) (we) last saw the deceased alive on 3/5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Marvin F. Siontz M.D.		23B. DATE SIGNED 3/5/65		23C. PHYSICIAN'S NAME (Type) MARVIN F. SIONTZ M.D.		23D. ADDRESS Sinai Hospital of Baltimore					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/8/1965		24C. NAME OF CEMETERY OR CREMATORY BALTO. HERREW		24D. LOCATION BALTO MD					
25A. DATE REC'D BY HEALTH DEPT. MAR 9 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR SYLVAN S. LEWIS + SON - 3319 OLYMPIA AVE		ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 2531					CERTIFICATE OF DEATH			Registered No. 65 2531	
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) SARAH BEST (BERNSTEIN)					MARCH 6, 1965 15 AM 8:15 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BELVEDERE NURSING HOME					A. STATE B. COUNTY MARYLAND				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 5350 NELSON AVENUE				
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 2/10-1901		9. AGE (In years last birthday) 64	
								If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT DR. MORRIS BEST 1013 UNIVERSITY BLVD, EAST SILVER SPRING, MARYLAND			
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH
					(A) DUE TO Carcinoma of uterus metastases				6 months
					(B) DUE TO none				
					(C) DUE TO				
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					none				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from OCT 13 1964 to March 6 1965, that (I) (we) last saw the deceased alive on March 6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Manuel Levin M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED March 6, 1965				
23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN					23D. ADDRESS M.D. 4818 REISTERSTOWN RD BALTO-15 MD				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/7/65		24C. NAME of CEMETERY or CREMATORY MARYLAND LODGE		24D. LOCATION (City, town, or county) (State) ROSEDALE MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. MAR 9 1965		25B. NAME OF REGISTRAR Robert E. Parker		25C. FUNERAL DIRECTOR ADDRESS SCL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD					



FUNERAL DIRECTOR: IMPORTANT

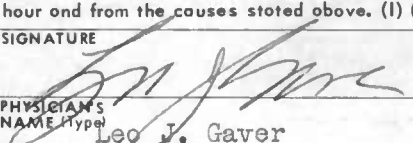
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2532</b>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b>		Registered No. <b>65 2532</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Harriett Roberts</b>			2. DATE AND HOUR OF DEATH <b>3/4/65 10:35 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ZION HILL CONVALESCENT HOME</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>18-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore City</b> D. STREET ADDRESS (If rural, give location) <b>1219 W. Fayett Street</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Mar. 16, 1881</b>	9. AGE (In years lost birthday) <b>83</b>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Domestige</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Tob Ward</b>			14. MOTHER'S MAIDEN NAME <b>Anna ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Oliver Roberts, 2753 Winchester St, Baltimore, Md.</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Coronary Insufficiency</b> DUE TO (B) <b>Arteriosclerotic Hypertensive</b> DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <b>About 1 hour</b> <b>3 + yrs.</b>					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1963</b> to <b>Mar 4 1965</b> , that (I) (we) last saw the deceased alive on <b>March 1 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Lucius W. Leaper</b>			23B. DATE SIGNED <b>3/4/65</b>		
23C. PHYSICIAN'S NAME (Type) <b>Lucius W. Leaper</b>			23D. ADDRESS <b>1200 Bloomingdale Rd.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/9/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Accomac, Cem.</b>	
24D. LOCATION <b>Accomac, Va.</b>		25A. DATE RECD BY HEALTH DEPT. <b>MAR 9 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.A.</b>		25C. FUNERAL DIRECTOR <b>Edgar Wharton - Accomac, VA</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 2533</b>	
BIRTH NO. <b>65 2533</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Margaret Evans Hughes Hufnagel</b>			March 7, 1965   8:25 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Anderson Nursing Home</b>			A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4415 Wentworth Road</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 28, 1874</b>	9. AGE (In years last birthday) <b>91</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher - retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
13. FATHER'S NAME <b>William F. Hackler</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
14. MOTHER'S MAIDEN NAME <b>Margaret Evans Hughes</b>			15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>219-22-2724</b>		17. INFORMANT ADDRESS <b>C. Herbert Hufnagel 4415 Wentworth Road</b>			
18. <b>450.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Generalized Arteriosclerosis, Advanced</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Nov. 19 54</b> to <b>March 19 65</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>March 6, 19 65</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE  M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>3/8/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Leo J. Gaver</b>		23D. ADDRESS <b>1 Mallow Hill Ave., Baltimore 29, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/10/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Greenmount Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Elsworth Armacost</b>			
ADDRESS <b>Elsworth Armacost 4600 Liberty Heights</b>					



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65 2534

BALTIMORE CITY HEALTH DEPARTMENT

65 2534

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ERIC X FOULK

2. DATE AND HOUR PRONOUNCED DEAD

March 4, 1965

12:05 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Union Memorial

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

520 Orkney Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov. 4, 1891

9. AGE (in years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months; Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Foundry

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U. S. A.

13. FATHER'S NAME

Wilson M. Foulk

14. MOTHER'S MAIDEN NAME

Kate Bond

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.  
unknown

17. INFORMANT

Mrs. Gertrude T. Foulk  
520 Orkney Rd. 12.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Conflagration with asphyxia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) carbon monoxide poisoning  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Acute ethylism

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

520 Orkney Rd.

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

3

3

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?

m.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Caught in house fire

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
3-4-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremation

23B. DATE

Mar. 5, 1965

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery Co.

23D. LOCATION (City, town, or county) (State)

3801 Frederick Avenue, Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 9 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

William E. Johnson - 8521 Loch Raven Blvd.

VALLEY FORGE

REGISTERED

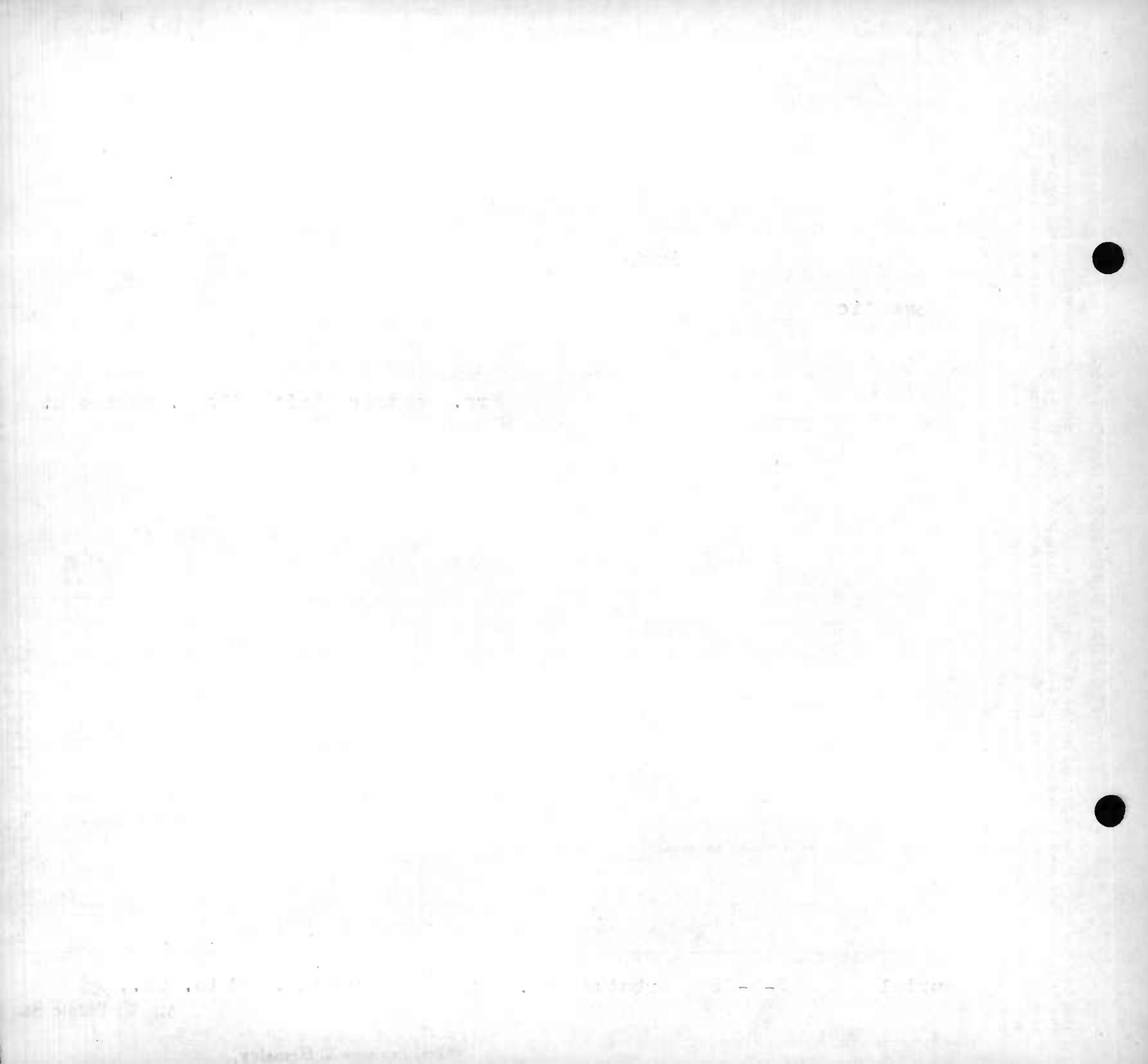
*Montgomery*

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 2535</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 2535</span>				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">HENSON, Grace</span>				3-4-65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">90 LINCOLN MEMORIAL</span>		(If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">27 N Carey</span>		A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.2em;">W. Hoffman</span>	
5. SEX <span style="font-size: 1.2em;">Female</span>		6. RACE <span style="font-size: 1.2em;">Color</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore Md</span>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Single</span>		8. DATE OF BIRTH <span style="font-size: 1.2em;">1900 Dec 25 64</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">17 02</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Domestic</span>		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <span style="font-size: 1.2em;">Albert Henson</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary Johnson</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Beatrice Smith 715 N. Monroe St</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		ADDRESS	
18. <span style="font-size: 1.2em;">422.1 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <span style="font-size: 1.2em;">Cardio Vascular Disease</span> <span style="font-size: 1.2em;">old L Hemiplegia</span> (B) DUE TO <span style="font-size: 1.2em;">Poly articular arthritis</span> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Nov 163</span> to <span style="font-size: 1.2em;">March 4</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">H. R. Johnson</span>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">403 med arts</span>				23D. ADDRESS <span style="font-size: 1.2em;">403 med arts</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<span style="font-size: 1.2em;">Burial</span>		<span style="font-size: 1.2em;">3-8-65</span>		<span style="font-size: 1.2em;">Arbutus Mem. Park</span>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<span style="font-size: 1.2em;">MAR 9 1965</span>		<span style="font-size: 1.2em;">Robert E. Taylor</span>		<span style="font-size: 1.2em;">578 W. Middle St.</span>	
VS 150-REV. 1/1/65					

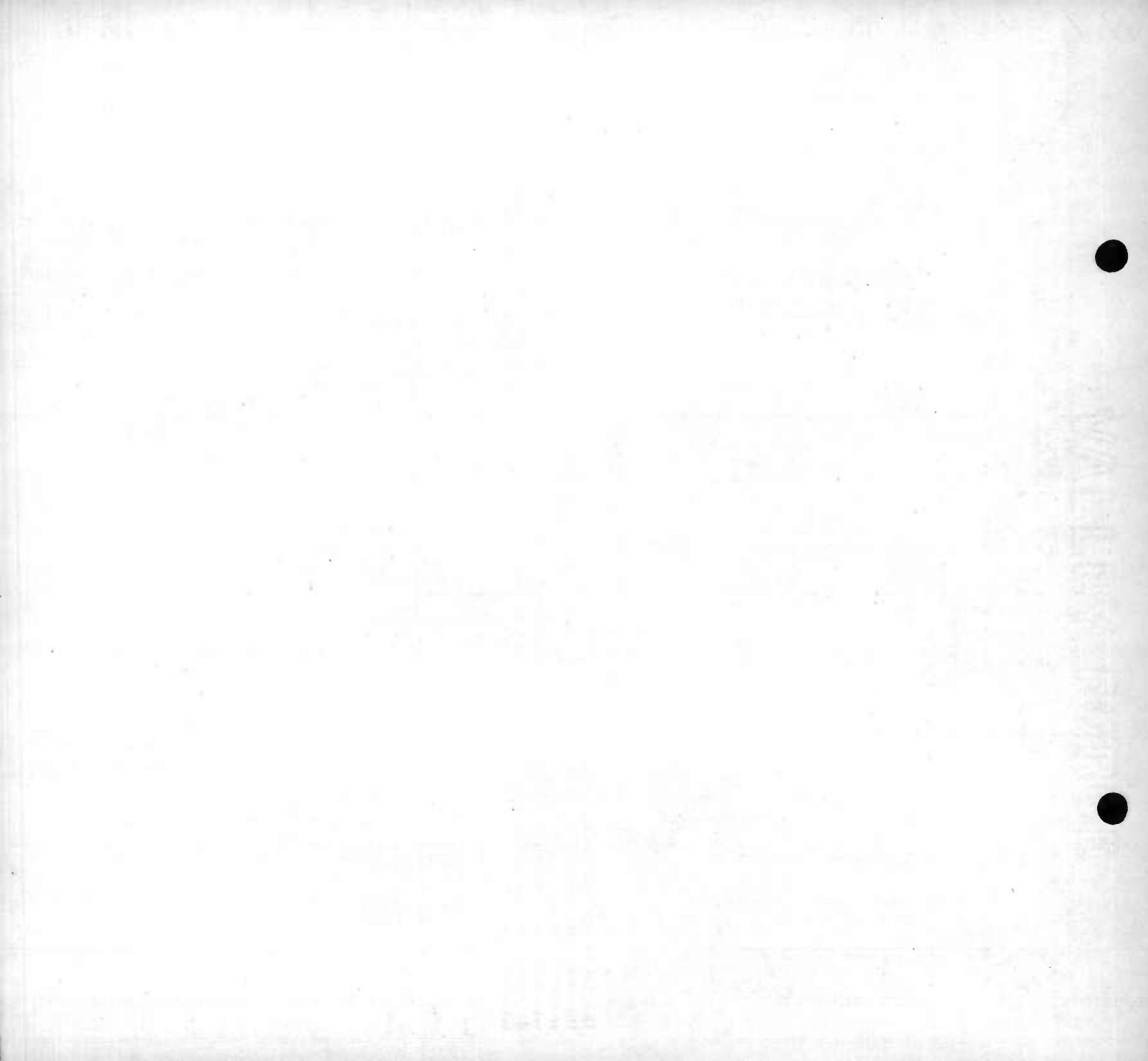
(Mrs) Frances A. Hensley



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2536		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2536	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Joseph Wieber		3-6-65- 4: 35 p.m.		4: 35 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 2007	
Bon Secours Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		3814 old Frederick Rd.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	White	Widowed	2-22-83	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Policeman Brushmaker Brush Co.				Balto. Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Henry J. Wieber		Len Deonges			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-05-3080		Balto. 29. Md. Mr. Louis Wieber 1126 Cooks Lane	
18. 177X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO		Carcinoma of Prostate	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO		and metastatic carcinoma	
ANTECEDENT CAUSES		(C) DUE TO		and arteriosclerosis	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 2-17-65 19 to 3-6-1965, that (I) (we) last saw the deceased alive on 3-6-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
DR. M. F. [Signature]		3/6/65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)	
Burial	3/10/65	New Cathedral CEM.	BALTO.	Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS		
MAR 9 1965	Robert E. Staley, M.D.	G. Truman Schwab	3512 Frederick Ave. (29)		

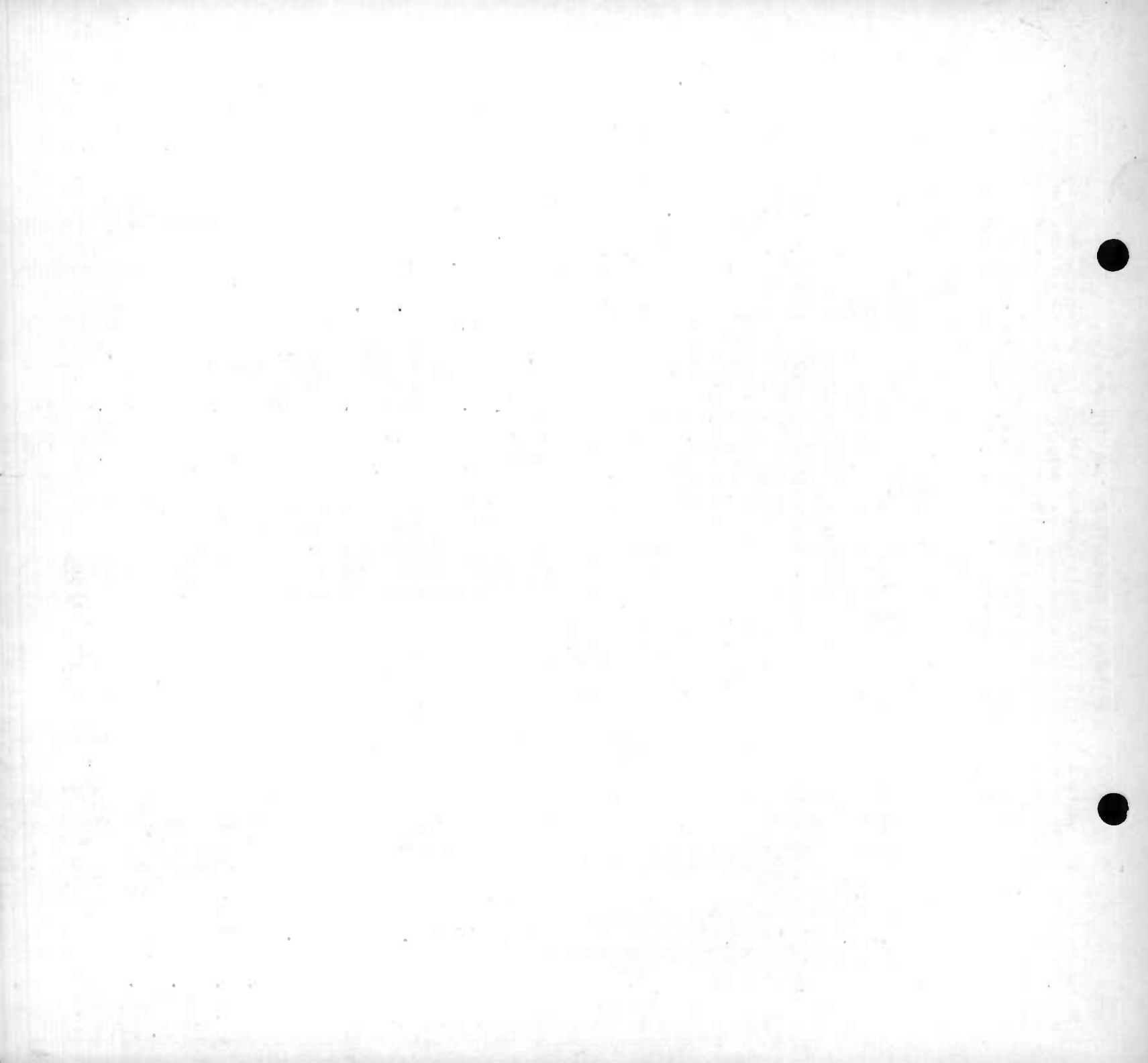




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2537		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 2537	
1. NAME OF DECEASED (Type or Print) William R. Meyers				2. DATE AND HOUR OF DEATH March 7, 1965 9:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1524 Jackson St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pasadena 32-00 D. STREET ADDRESS (If rural, give location) Pine Haven			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Jan. 13, 1896	9. AGE (In years lost birthday) 69	10. If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cutter		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Meyers				14. MOTHER'S MAIDEN NAME Sophia Ricker			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Theresa E. Meyers Pine Haven, Pasadena Md			
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO COPD (B) DUE TO Generalized Metastasis (C)		INTERVAL BETWEEN ONSET AND DEATH 4 Mo.	
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/1/65 to 3/1/65 and that (I) (we) last saw the deceased alive on 3/1/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. S. Ellison, M.D.				23B. DATE SIGNED 3/8/65		23C. PHYSICIAN'S NAME (Type) E. S. Ellison, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE B 11 65		24C. NAME OF CEMETERY OR CREMATORY Holy Cross		24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 9 1965		25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR Mc Gully 2		ADDRESS 130 E. Fort Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2538	
BIRTH NO. 65 2538		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ELIZABETH SCHLAUCH</b>		2. DATE AND HOUR OF DEATH <b>March 5, 1965</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>24-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>443 E. Grindall St.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		D. STREET ADDRESS (If rural, give location) <b>443 E. Grindall St.</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>5/15/78</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Hungary</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family - Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Fracture of Hip</b>		CAUSE OF DEATH (A) <b>Acute pulmonary edema</b> DUE TO (B) <b>Arteriosclerotic Heart Disease</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>Jan 1965</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>For right hip</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examiner) <b>Fracture of hip</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>443 E. Grindall St. Balt.</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>Jan 14, 1965</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell on floor</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 3</b> 19 <b>65</b> to <b>March 5</b> 19 <b>65</b> and that (I) (we) last saw the deceased alive on <b>March 5</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ricardo Lozada</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/8/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICARDO LOZADA</b>		23D. ADDRESS <b>1228 Schaner St. Balt. 31 and</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>B</b>		24B. DATE <b>3/9/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>	
24D. LOCATION <b>Baltimore</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>McGilly - 130 E. Fort Avenue</b>			



B-520

65 2539

BALTIMORE CITY HEALTH DEPARTMENT

65 2539

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

THOMAS BUNAS (Gus Petrou Bunas)

2. DATE AND HOUR PRONOUNCED DEAD

March 4, 1965

2:40 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2410 Fairmount Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2410 Fairmount Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

2-25-95

9. AGE (In years  
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Tailor

11. BIRTHPLACE (State or foreign country)

Turkey

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W. W. I

16. SOCIAL  
SECURITY NO.

217-12-9080

17. INFORMANT

Anthony Karageorge

ADDRESS

2914 E. Baltimore St., Baltimore, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-4-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/8/65

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 9 1965

24B. NAME OF REGISTRAR

Robert E. Tarkenton

24C. FUNERAL DIRECTOR

Nicholas T. Matthews

ADDRESS

3021 Eastern Ave., Baltimore, Md.

VALENTINE CORP.

WASHINGTON

*Handwritten signature*

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2540				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2540	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mildred E. Murphy				2. DATE AND HOUR OF DEATH March 7, 1965 10:35 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 34 D. STREET ADDRESS (If rural, give location) 1318 Mantle St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH September 17, 1908	9. AGE (In years last birthday) 57-56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Thomas Steven				
14. MOTHER'S MAIDEN NAME Emily Drear			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. none			17. INFORMANT ADDRESS Luke J. Murphy, 1318 Mantle Street, Baltimore				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Sub Arachnoid Hemorrhage (B) Hypertensive Cardio Vascular Dis. (C)			
INTERVAL BETWEEN ONSET AND DEATH ? 12 hours				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 7, 1965 to March 7, 1965, that (I) (we) last saw the deceased alive on March 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE L. G. Tilley				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED March 7, 1965	
23C. PHYSICIAN'S NAME (Type) L. G. Tilley				23D. ADDRESS M.D. Maryland General Hospital			
24A. BURIAL CREATION, REMOVAL (Specify) BURIAL		24B. DATE 3-11-65		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. MAR 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Hamilton, Inc., 6009 Harford Road 14			



V.S. 153

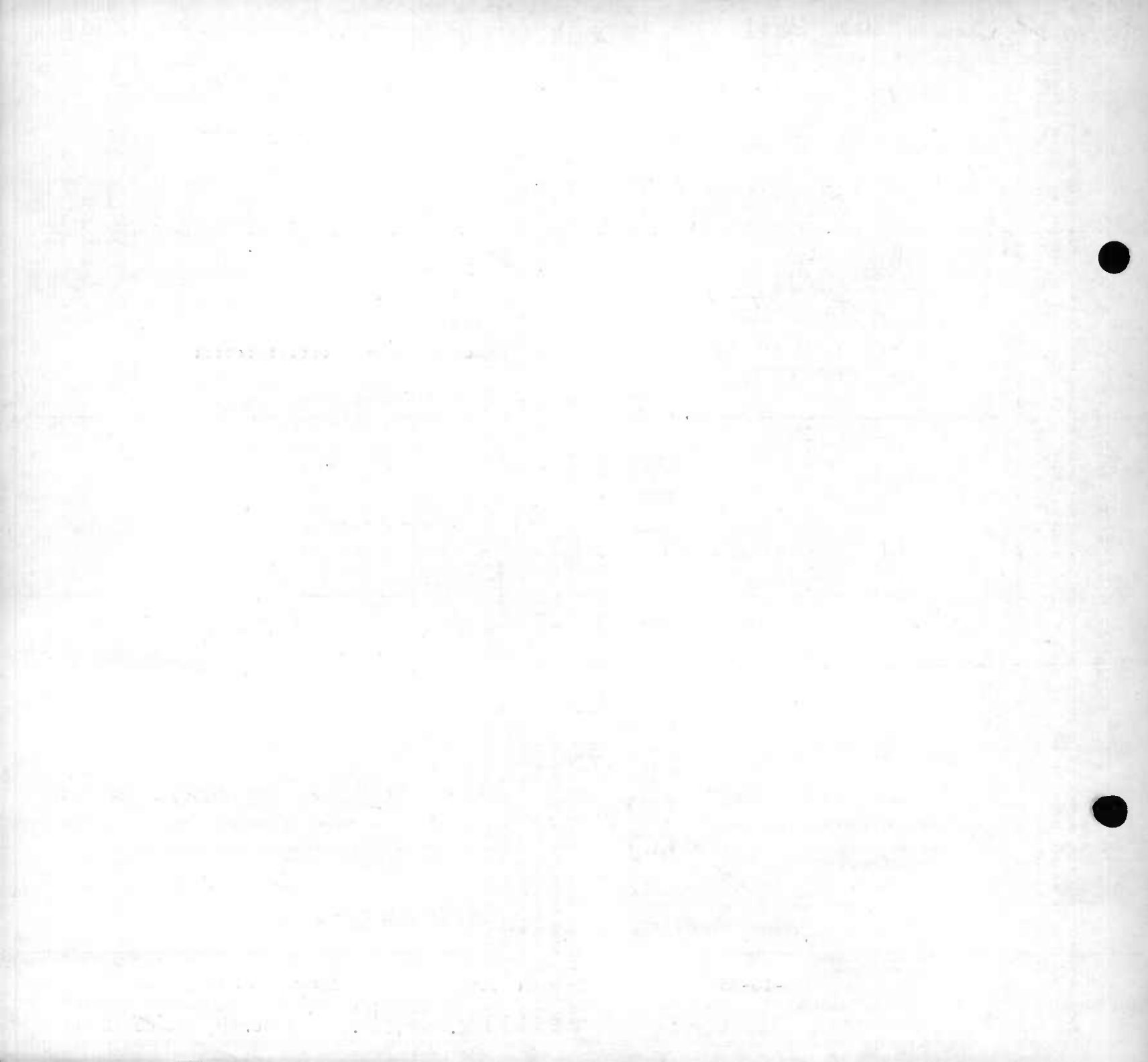
4-6-65

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 2541</u>	
BIRTH NO. <u>65 2541</u>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JOHN JERRY KRAGER</u>	
2. DATE AND HOUR OF DEATH <u>March 6, 1965 10:40 P.M.</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>CARROLL</u>		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MONTEBELLO STATE HOSP.</u>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Finksburg 56-00</u>		D. STREET ADDRESS (If rural, give location) <u>Rural Route 2 BOX 130</u>	
6. SEX <u>M</u>	7. RACE <u>W</u>	8. MARRIED (NEVER MARRIED) WIDOWED, DIVORCED (Specify) <u>(P) 11/24/1957</u>	9. DATE OF BIRTH <u>7/27/1892</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no data - Retired 1957</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM KRAGER</u>	
14. MOTHER'S MAIDEN NAME <u>Agnes Staia</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>215-09-1832</u>		17. INFORMANT <u>MARTHA RIDINGER</u>	
18. ADDRESS <u>525 N. Belvoir Ave.</u>		19. CAUSE OF DEATH (SISTER) <u>Cerebral Thrombosis?</u>	
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		21. INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Arteriosclerotic Heart Disease ± 4 yr.</u>			
22A. DATE OF OPERATION <u>0</u>	22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	22C. AUTOPSY? (Yes or No) <u>No</u>	22D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
23A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	23B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	23C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
24A. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	24B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	24C. HOW DID INJURY OCCUR?	
25. I certify that (I) (this hospital) attended the deceased from <u>Feb. 10</u> 19 <u>65</u> to <u>March 6</u> 19 <u>65</u> , that (I) (we) lost saw the deceased alive on <u>March 5</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
26A. SIGNATURE <u>Reuben Guerrero</u>		26B. DATE SIGNED <u>3/6/65</u>	
27A. PHYSICIAN'S NAME (Type) <u>Reuben Guerrero</u>		27B. ADDRESS <u>Montebello State Hospital</u>	
28A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	28B. DATE <u>3-10-65</u>	28C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	28D. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>
29A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1965</u>	29B. NAME OF REGISTRAR <u>Robert E. Bailey</u>	29C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook, Inc., 1217 St. Paul Street, 21202</u>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2542		CERTIFICATE OF DEATH		Registered No. 65 2542	
1. NAME OF DECEASED (Type or Print) <b>ISREAL SKY</b>				2. DATE AND HOUR OF DEATH <b>3-7-65 17:40 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>PENNSYLVANIA</b> B. COUNTY <b>V-35</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>ALTOONA</b> D. STREET ADDRESS (If rural, give location) <b>203 COLERIDGE AVE.</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>5-7-02</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>President Sky Bros. Wholesale Food</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Lithuania</b>			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>DAVID SKY</b>			14. MOTHER'S MAIDEN NAME <b>SARAH <del>PALAKAVETZ</del> Polakavetz</b>			17. INFORMANT ADDRESS <b>Lafferty Funeral Home, Altoona, Pennsylvania</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>209-20-4810</b>						
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary artery Disease</b>				CAUSE OF DEATH (A) DUE TO <b>Post op lysis of adhesions for intestinal obstruction.</b> (B) DUE TO <b>Post cardiac arrest</b> (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Chemia, pulmonary embolism.</b>					
19A. DATE OF OPERATION <b>3/6/65 11AM</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>intestinal obstruction</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <b>2/28</b> 19 <b>65</b> to <b>3/7</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3/7</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <u>did</u> ) (did not) view the body after death.									
23A. SIGNATURE <b>Carl E. Bredenberg</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/7/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>CARL E. BREDEBERG</b>				23D. ADDRESS M.D. <b>JOHNS HOPKINS HOSPITAL, BALTIMORE, 5, MD.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24B. DATE <b>3-8-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Agudath Achim</b>		24D. LOCATION (City, town, or county) (State) <b>Altoona, Pa.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		ADDRESS <b>21202</b>			

Y2

JOHN J. HENNEL

Y2 IVA

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2543				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 65 2543	
M.E. CASE NO. 65 2543				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ANNIE BOYD</b>				2. DATE AND HOUR OF DEATH <b>MARCH 8, 1965</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2305 Ellamont St.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15-47</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2305 Ellamont St.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>COLORED</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3-9-1890</b>	9. AGE (in years last birthday) <b>74</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			11. BIRTHPLACE (State or foreign country) <b>BRUNSWICK CO., VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>WILLIAM WALKER</b>			14. MOTHER'S MAIDEN NAME <b>BETTY PARKER WALKER</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>CORRINE FOWLER, 2305 ELLAMONT ST.</b>		
18. <b>153.6 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Carcinomatosis;</b> DUE TO (B) <b>Carcinoma of Colon.</b> DUE TO (C) <b>3 months</b> <b>6 months</b>				INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nufify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-25-1964</b> to <b>3-7-1965</b> , that (I) (we) last saw the deceased alive on <b>3-6-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>I. Bradshaw Higgins</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3-8-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>I. BRADSHAW HIGGINS</b>				23D. ADDRESS M.D. <b>2243 Madison Ave. Balt. Md. 21217</b>			
24A. BURIAL REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-11-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>GOODHOPE BAPTIST CHURCH</b>		24D. LOCATION (City, town, or county) (State) <b>BLACKRIDGE, VA.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>JONES FUNERAL HOME</b>		ADDRESS <b>LAWRENCEVILLE, VA</b>	

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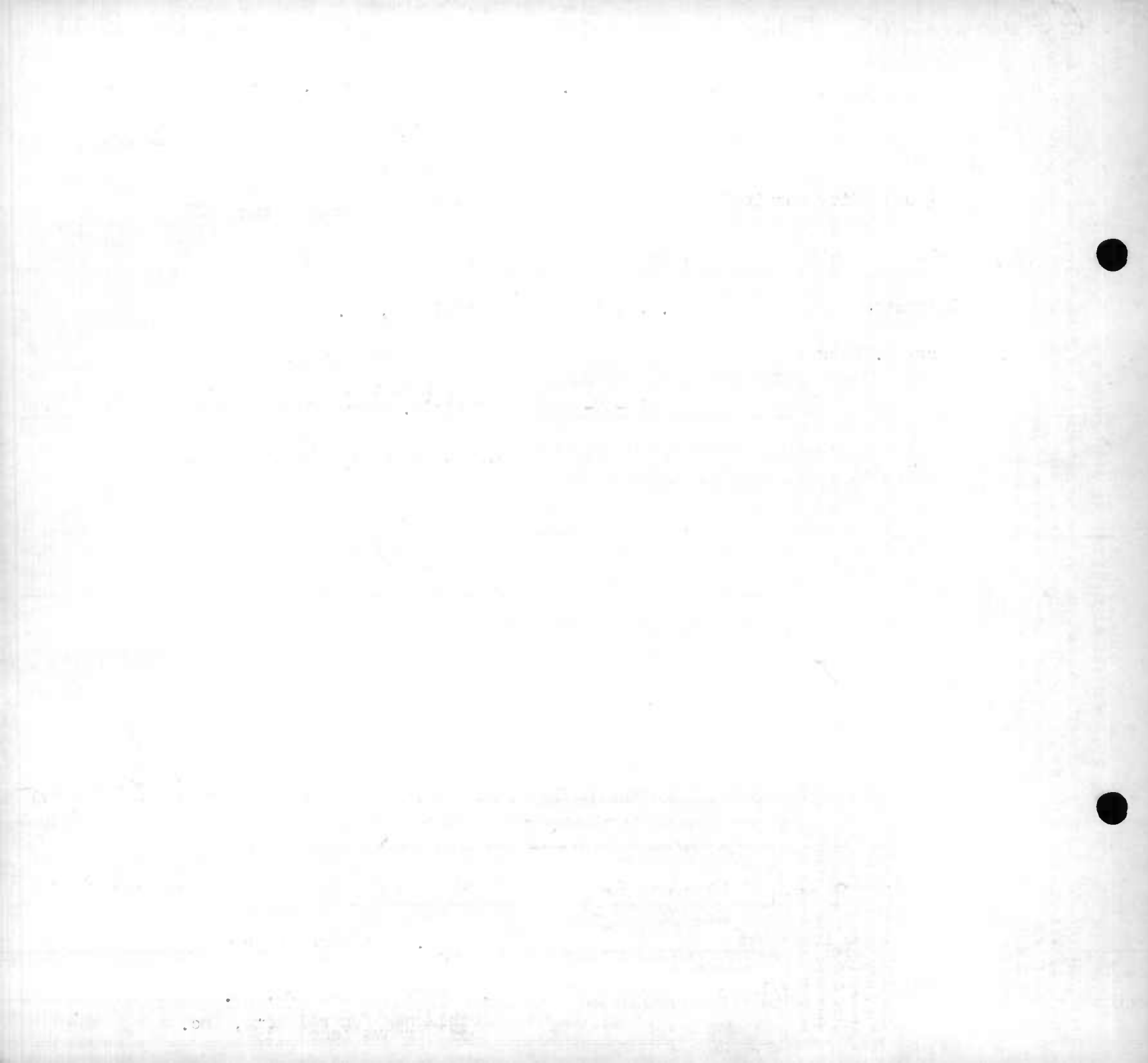
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

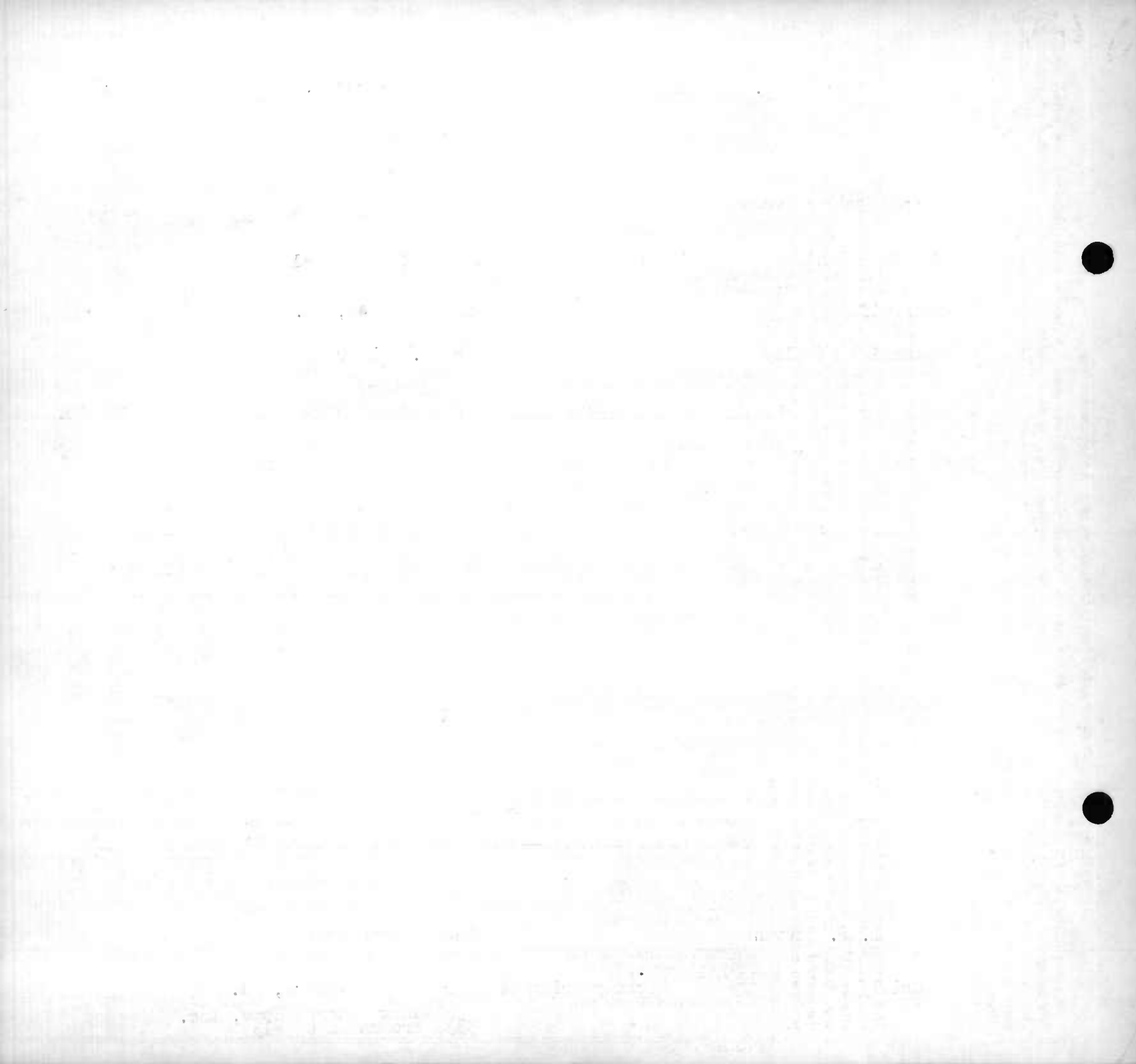
BIRTH NO. <b>65 2544</b>		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. <b>65 2544</b>	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>EDWARD CARROLL BERRY SR.</b>			2. DATE AND HOUR OF DEATH <b>March 6, 1965</b>		
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>(DCA) City Hospital</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>1529 Chilworth Avenue #20</b>		
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>12/5/1914</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Harry E. Berry</b>			14. MOTHER'S MAIDEN NAME <b>? Richardson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-07-9645</b>		17. INFORMANT (nee Gattion) <b>Katie P. Berry</b>	
				ADDRESS <b>1529 Chilworth Avenue #20</b>	
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute coronary thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 20</b> 19 <b>65</b> to <b>March 6</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>March 4</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>Andrew Lemischka</b>				23B. DATE SIGNED <b>March 8-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Andrew Lemischka</b>				23D. ADDRESS <b>2608 E. Baltimore Street</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/10/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Schimineck Funeral Home, Ind.</b>	
				ADDRESS <b>3331 Brehms Lane #13</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

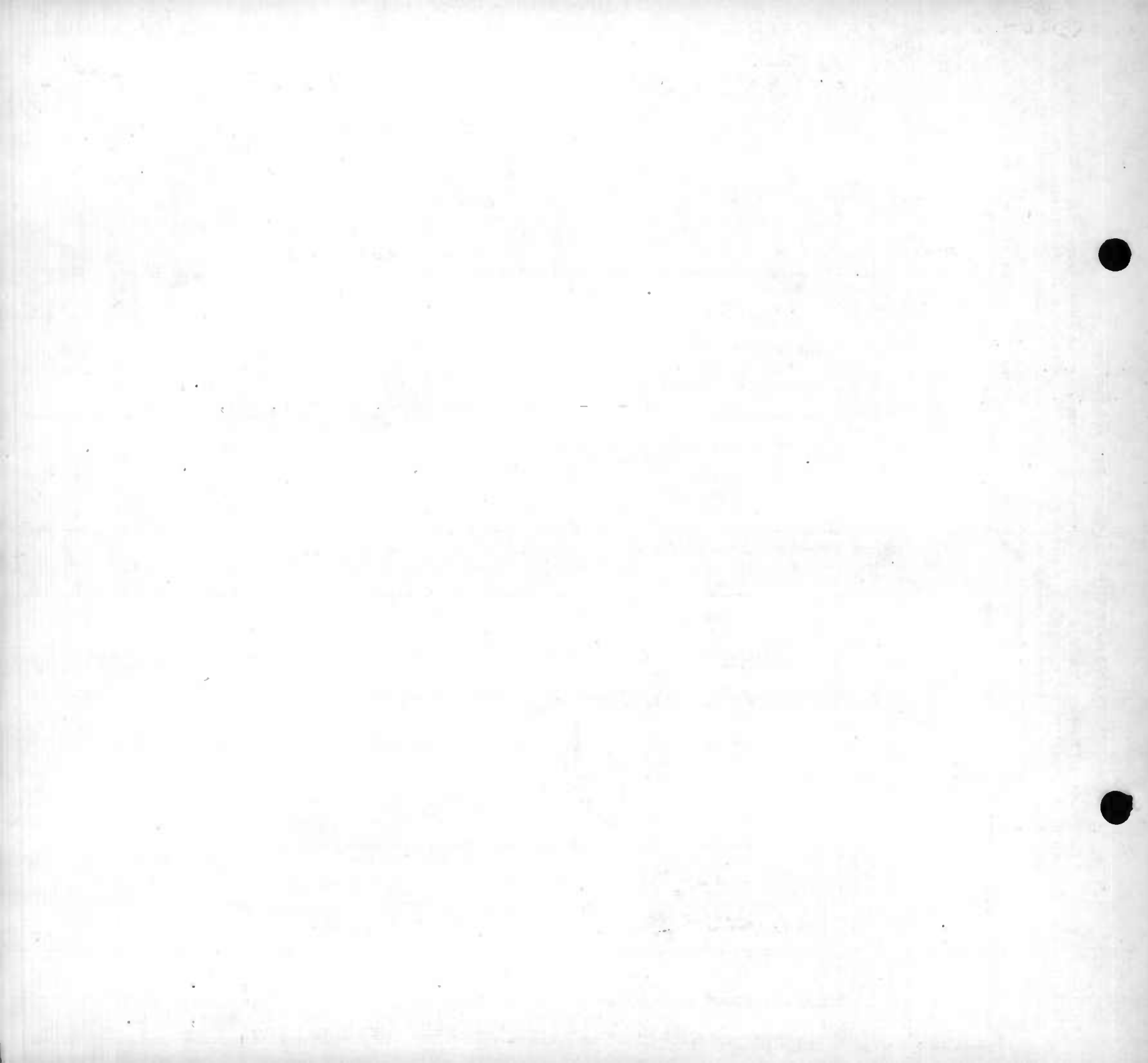
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2545		CERTIFICATE OF DEATH		Registered No. 65 2545	
1. NAME OF DECEASED (Type or Print) <b>AMANDA R. PURNELL</b>				2. DATE AND HOUR OF DEATH <b>March 7, 1965 10:10 am M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>3323 Dudley Avenue</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3323 Dudley Avenue</b>					
5. SEX <b>female</b>		6. RACE <b>white</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>		8. DATE OF BIRTH <b>6/2/1873</b>		9. AGE (In years last birthday) <b>91</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Piney Plains, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Nathaniel Hartley</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Haller</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT (daughter) <b>Mary (Purnell) Goetzke 3323 Dudley Avenue</b>			
18. <b>481X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Congestive Heart Failure</b> DUE TO (B) <b>Arteriosclerotic C.V. disease</b> DUE TO (C) <b>Acute Grippe Infection</b>				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/11</b> 19 <b>55</b> to <b>3/7</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3/5</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>L. B. Stevens</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>L. B. Stevens</b>				23D. ADDRESS <b>3400 Erdman Avenue</b>					
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/11/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Thomas Episcopal Presbyterian Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Hancock, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>				25B. NAME OF REGISTRAR <b>R. B. E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane #13</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <span style="font-size: 1.2em;">65 2546</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 2546</span>		M.E. CASE NO.		1. NAME OF DECEASED <span style="font-size: 1.2em;">LANCAR, GEORGE</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3-6-65 7:20 A.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <span style="font-size: 1.2em;">Baltimore Maryland.</span>			
<span style="font-size: 1.2em;">Lutheran hosp. of Maryland</span>				C. CITY OR TOWN (If outside city limits, give RURAL and give township)			
				<span style="font-size: 1.2em;">Baltimore M.D. 24 26-07</span>			
				D. STREET ADDRESS (If rural, give location)			
				<span style="font-size: 1.2em;">507 S. MACON ST. 507 S. MACON ST</span>			
5. SEX <span style="font-size: 1.2em;">male</span>	6. RACE <span style="font-size: 1.2em;">white</span>	7. MARRIED, NEVER MARRIED <span style="font-size: 1.2em;">WIDOWED, DIVORCED (specify)</span>		8. DATE OF BIRTH <span style="font-size: 1.2em;">1894 5-25-1894</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">70</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<span style="font-size: 1.2em;">retired Crane Operator</span>		<span style="font-size: 1.2em;">Beth. Steel</span>		<span style="font-size: 1.2em;">Glena, Yugoslavia</span>		<span style="font-size: 1.2em;">U.S.A.</span>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<span style="font-size: 1.2em;">unknown</span>				<span style="font-size: 1.2em;">unknown</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		<span style="font-size: 1.2em;">213-07-8929</span>		<span style="font-size: 1.2em;">5600 Denwood Ave., #6 George R. Loncar, son,</span>			
18. <span style="font-size: 1.2em;">4341 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO <span style="font-size: 1.2em;">pulmonary edema</span>			
ANTECEDENT CAUSES				(B) DUE TO <span style="font-size: 1.2em;">secondary to congestive heart failure</span>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II				<span style="font-size: 1.2em;">Pneumonia</span>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<span style="font-size: 1.2em;">0</span>				<span style="font-size: 1.2em;">No</span>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-5</span> 1965 to <span style="font-size: 1.2em;">3-6</span> 1965, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3-5</span> 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">G.H. P.D.I.B.</span>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">3-6-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">G.H. P.D.I.B.</span>				23D. ADDRESS <span style="font-size: 1.2em;">Lutheran hospital of Maryland.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<span style="font-size: 1.2em;">Burial</span>		<span style="font-size: 1.2em;">3/9/65</span>		<span style="font-size: 1.2em;">Holy Redeemer Cem.</span>		<span style="font-size: 1.2em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<span style="font-size: 1.2em;">MAR 9 1965</span>		<span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		<span style="font-size: 1.2em;">Schimunek Funeral Home, Inc.</span>		<span style="font-size: 1.2em;">3331 Brehms Lane</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.5em;">65 2547</span>	
BIRTH NO. <span style="font-size: 1.5em;">65 2547</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">BAUER Mrs. Alice P.</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3/5/65</span> <span style="float: right;">4:05 P.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">26-02</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span>	
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">48 MARYLAND GENERAL</span>		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">4218 Parkside Drive #6,</span>			
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <span style="font-size: 1.2em;">3/4/95</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">70</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">House Wife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">at home</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore Md.</span>	12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Dietrich Kahl</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Unetta Fraley, ?</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-05-4529</span>	17. INFORMANT <span style="font-size: 1.2em;">Ambrose Bauer, husband, above</span>		ADDRESS <span style="font-size: 1.2em;">same</span>
18. <span style="font-size: 1.2em;">290.2 I</span> CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) DUE TO <span style="font-size: 1.2em;">Macrocyclic anemia</span>					
(B) DUE TO <span style="font-size: 1.2em;">Unknown Cause</span>					
(C) DUE TO <span style="font-size: 1.2em;">① hepatomegaly</span>					
<span style="font-size: 1.2em;">② anasarca</span>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">no</span>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">2/4</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">3/5</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">4:05 3/5</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Joo Hyun Sohn</span> M.D.				23B. DATE SIGNED <span style="font-size: 1.2em;">3/5/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">JOO HYUN SOHN</span> M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">3/9/65</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Loudon Park Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 9 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Parker</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Schimmunek Funeral Home, Inc.</span> <span style="font-size: 1.2em;">43331 Brehms Lane</span>	



Magnum



Magnum

Dietrich Kahl

Magnum

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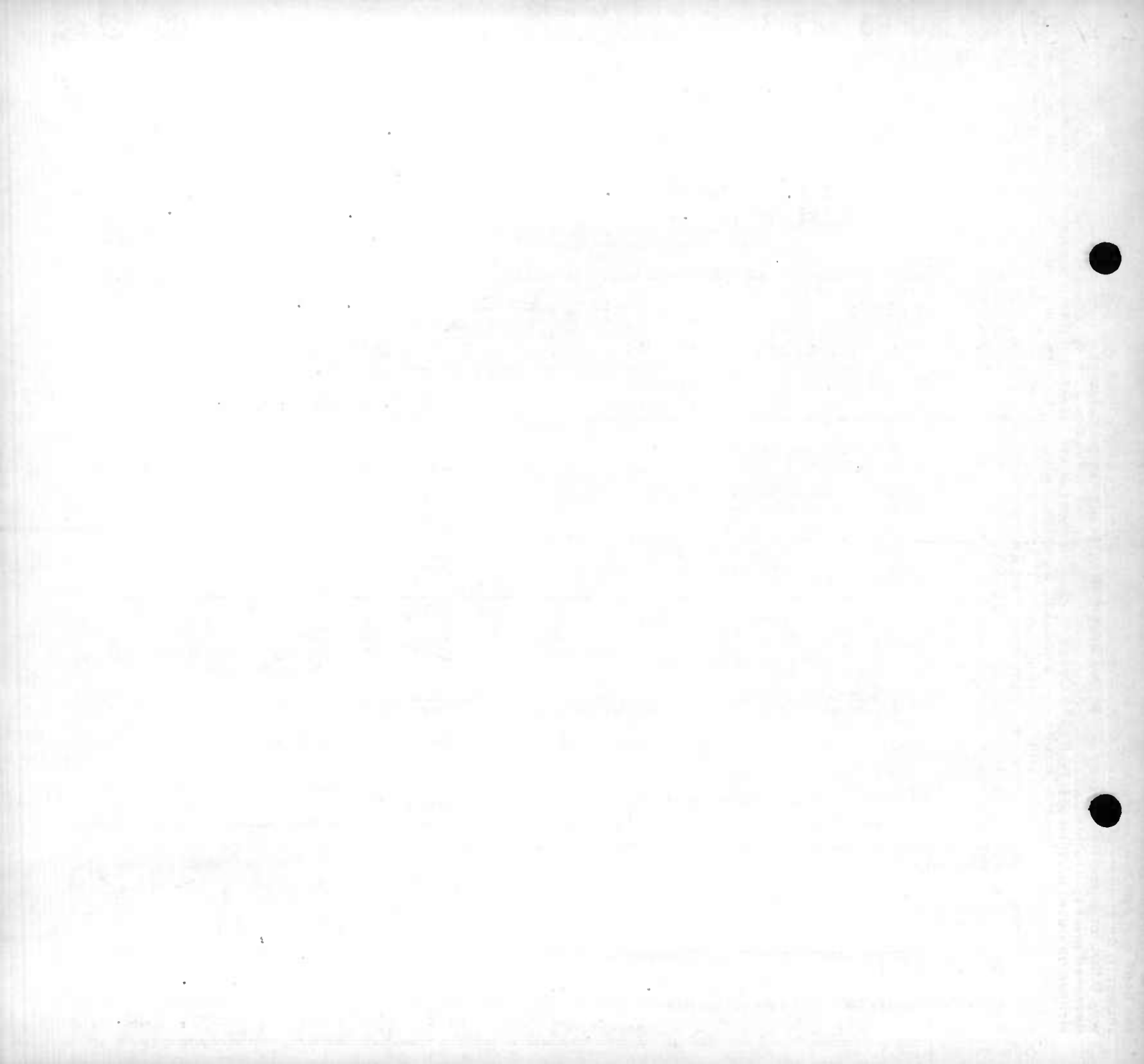
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

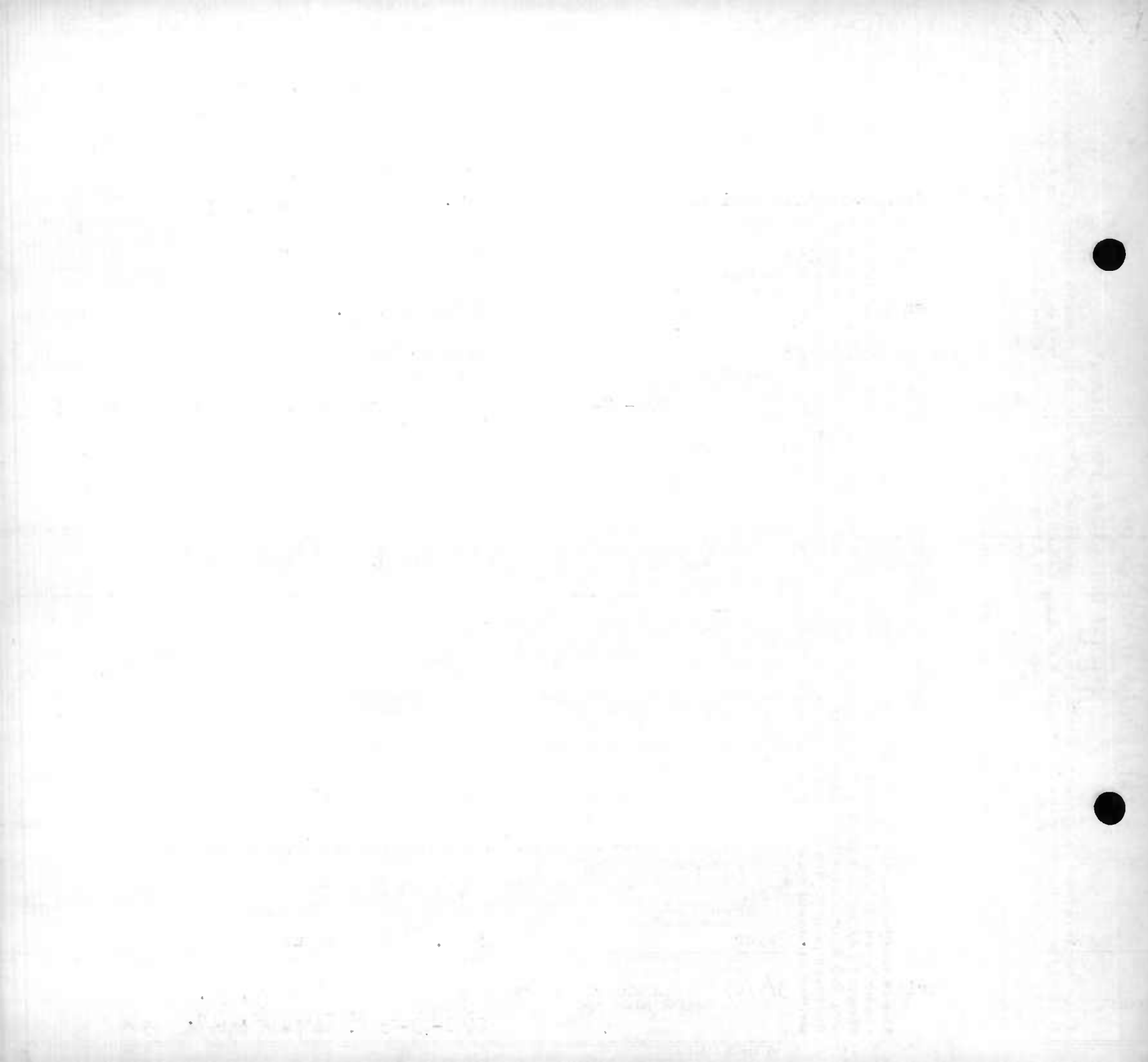
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2548		CERTIFICATE OF DEATH		Registered No. 65 2548	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Dora Altwater</b>		2. DATE AND HOUR OF DEATH <b>3-7-65 530 P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>7-02</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>911 N. Montford Ave., Baltimore, Md., 21205</b>				D. STREET ADDRESS (If rural, give location) <b>911 N. Montford Ave.</b>					
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>8/14/89</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Charlady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Northeastern Sup Co</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Charles Habersack</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Marion F. Tlasek, dght.</b>		ADDRESS <b>4431 Harcourt Rd</b>			
18. <b>1992 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cancer</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Cancer</b> DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>September 1964</b> to <b>Mar. 7, 1965</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>March 5, 1965</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>R. Donald J. Anderson</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3-7-65</b>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <b>6077 Harford Rd.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/11/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Carmel Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Staley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Schmunk Funeral Home, Inc.</b>		ADDRESS <b>3430 Brehms Lane</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2549	
BIRTH NO. 65 2549					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
ANNA DOBIHAL			March 6, 1965 4:30 pm M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  Johns Hopkins Hospital			A. STATE Maryland B. COUNTY 6-02		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2445 Jefferson Street #5		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
female	white	married	7/26/1890	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife		at home		Baltimore, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Joseph Kolmaznik			Anna Kaplan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		216-07-4844		Jerry Kobihal 2445 Jefferson Street #5	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  287X I			CAUSE OF DEATH (A) DUE TO Congestive heart failure (B) DUE TO Myocardial infarction (C) DUE TO Chorea - Chorea		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 112		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 2</u> 19 <u>65</u> to <u>Mar 6</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Feb 2</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <u>W.C.A. Hopkins</u>					
23A. SIGNATURE <u>W.C.A. Hopkins</u>			23B. DATE SIGNED <u>3/8/65</u>		
23C. PHYSICIAN'S NAME (Type) William G. Geyer			23D. ADDRESS M.D. 156 N. Milton Avenue		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/9/65		Meadowridge Cemetery	
24D. LOCATION (City, town, or county)		24E. ADDRESS (State)			
Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 9 1965		Robert E. Taylor, M.D.		Schimberk Funeral Home, Inc. 2601-03-05 E. Madison Street #5	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2550		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2550	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		BUCKWALTER, MENNO		2. DATE AND HOUR OF DEATH 3/5/65 11:00 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		A. STATE MD.		B. COUNTY BALTO.	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		53-00	
		D. STREET ADDRESS (If rural, give location) 28 N. PROSPECT AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-1-90	9. AGE (In years last birthday) 73	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookstore Clerk		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) PA.	
13. FATHER'S NAME Malcolm (MALCOLM) Buckwalter		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 172-01-4803		17. INFORMANT ST. AGNES HOSP. WILKENS & CATON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CORONARY INSUFF., ASCVD		CAUSE OF DEATH 1. CORONARY INSUFF., ASCVD		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO 2. POSS. CVA			
(B) DUE TO		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-24 19 65 to 3-5-19 65, that (I) (we) last saw the deceased alive on 3-5-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edilberto Beltran		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/5/65	
23C. PHYSICIAN'S NAME (Type) EDILBERTO BELTRAN		M.D. 23D. ADDRESS ST. AGNES HOSP. BALTO. 29, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-8-1965		24C. NAME of CEMETERY or CREMATORY Old Mennonite Cemetery Lancaster - Pennsylvania	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD		25A. DATE REC'D BY HEALTH DEPT. MAR 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Edilberto Beltran		25D. ADDRESS Caton Ave - Md			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2551		CERTIFICATE OF DEATH		Registered No. 65 2551	
1. NAME OF DECEASED (Type or Print) <b>LEONARD FREDERICK GRANT</b>				2. DATE AND HOUR OF DEATH <b>3-4-65 1 11<sup>55</sup> P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Towson 53-00</b>					
				D. STREET ADDRESS (If rural, give location) <b>8 Edgecliff Road</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8-22-04</b>		9. AGE (In years last birthday) <b>60</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSTALLATION ENGR.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>AIR CONDITIONING DIV. ARMSTRONG CORP.</b>			11. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Grant</b>				14. MOTHER'S MAIDEN NAME <b>Florence Leah Anderson</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO NONE</b>				16. SOCIAL SECURITY NO. <b>412-01-4237</b>		17. INFORMANT ADDRESS <b>chart - Union Memorial Hospital</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>421.0 I</b>				CAUSE OF DEATH (A) DUE TO <b>Acute and mitral valvulitis nodulif</b>				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>Pulmonary emboli, massive</b>					
				(C) <b>Extremal</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <b>2-25-1965</b> to <b>3-4-1965</b> , that (2) (we) last saw the deceased alive on <b>3-4-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Lawrence J. Lieberman</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-4-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>LAWRENCE J. LIEBERMAN</b>				23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>MAR 8, 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>PRUID RIDGE CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>PIKESVILLE, MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>		25B. NAME OF REGISTRAR <b>Cliff E. Taylor</b>		25C. FUNERAL DIRECTOR <b>John B. Smith</b>		ADDRESS <b>Towson, Md.</b>			

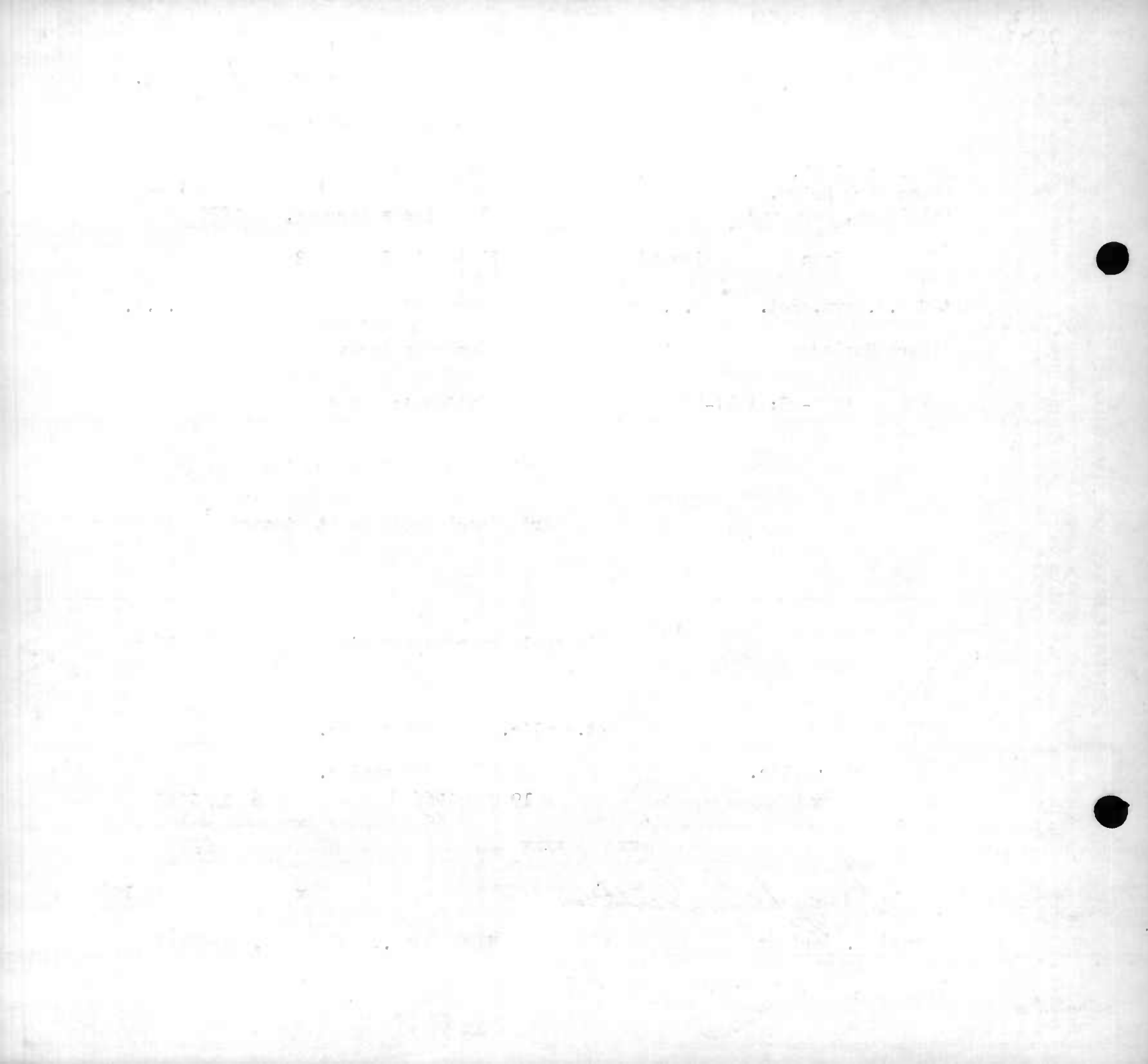




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2552		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2552	
M.E. CASE NO.			2		
1. NAME OF DECEASED (Type or Print) <b>RUTLEDGE, THOMAS ALBERT</b>			2. DATE AND HOUR OF DEATH <b>6 MAR 1965 9:06 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>USPHS Hospital, Wyman Park Drive, Baltimore, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1244 Leads Terrace, (27)</b>		
5. SEX <b>MALE</b>	6. RACE <b>Cauc</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>11 APR 1882</b>	9. AGE (In years lost birthday) <b>82</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LtJG U.S. Navy, Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Albert Rutledge</b>			14. MOTHER'S MAIDEN NAME <b>Josephie Jackson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 1900-23; 1941-45</b>		16. SOCIAL SECURITY NO. <b>219-01-9481</b>	17. INFORMANT ADDRESS <b>Patient's Chart</b>		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> DUE TO <b>Arteriosclerotic Heart Disease</b> DUE TO <b>Bilateral Bronchopneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>15 years</b> <b>15 days</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2 NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Not applic.</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Not applic.</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>Not applic.</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Not applic.</b>	
22. I certify that <del>IX</del> (this hospital) attended the deceased from <b>19 FEB 1965</b> to <b>6 MAR 1965</b> that <del>IX</del> (we) last saw the deceased alive on <b>6 MAR 19 65</b> and that in <del>IX</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>IX</del> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Frank A. Bartkus</i> M.D. 23C. PHYSICIAN'S NAME (Type) <b>Frank A. Bartkus</b>				23B. DATE SIGNED <b>6 MAR 1965</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-9-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore - Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>301 Fredrick Rd</b>			



BIRTH NO. 65 2553		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2553	
M.E. CASE NO. C.		1. NAME OF DECEASED (Type or Print) <u>HELEN HALFORD.</u> <u>HELEN HALEFORD-</u> (Halford)		2. DATE AND HOUR PRONOUNCED DEAD March 2, 1965 5:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>	
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>never married</u>	
8. DATE OF BIRTH <u>Sept-7/1899</u>		9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>	
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>could not ascertain</u>	
14. MOTHER'S MAIDEN NAME <u>could not ascertain</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>466-10-7004</u>	
17. INFORMANT <u>Mrs. W. W. White (friend)</u>		18. ADDRESS <u>500 1/2 E-42-St. City-18</u>		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hypertensive cardiovascular disease</u> DUE TO (A) <u>Hypertensive cardiovascular disease</u> (B) <u></u> (C) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u></u>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u></u>		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u></u>		22. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u></u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u> 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u></u> 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <u></u> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u></u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u></u> 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u></u> 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <u></u> 21F. HOW DID INJURY OCCUR? <u></u> 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		23B. DATE <u>March-9-65</u>		23C. NAME OF CEMETERY or CREMATORY <u>Lorraine</u>	
23D. LOCATION (City, town, or county) (State) <u>Woodlawn, Balto. Co Md. 21207</u>		24A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1965</u>		24B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
24C. FUNERAL DIRECTOR <u>Steger &amp; Woven Co 108-N-North-Av. City-1/</u>		24D. ADDRESS <u></u>		24E. SIGNATURE OF EXAMINER <u>John E. Adams, M.D.</u>	

WALLEY PONGE

65 2554

BALTIMORE CITY HEALTH DEPARTMENT

65 2554

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Wilbart E. Thamert

2. DATE AND HOUR PRONOUNCED DEAD

March 6, 1965 10:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Church Home &amp; Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

406 S. Bond Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)  
Single

8. DATE OF BIRTH

Nov. 3, 1907

9. AGE (In years  
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Lord Baltimore Hotel

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Thamert

14. MOTHER'S MAIDEN NAME

Catherine Gegner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.  
219-05-5114

17. INFORMANT

ADDRESS

Charles Zimmerman 359 S. Cornwall Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Massive pulmonary embolism  
DUE TO thrombophlebitis, left popliteal  
veins

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 7, 1965

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3-10-1965

23C. NAME OF CEMETERY or CREMATORY

Oak Lawn

23D. LOCATION

(City, town, or county)

(State)

Baltimore County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 9 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

ADDRESS

Lilly &amp; Zeiler Inc. 1901 Eastern Ave.

WALLACE PRODIGE

HAS DOTTEN

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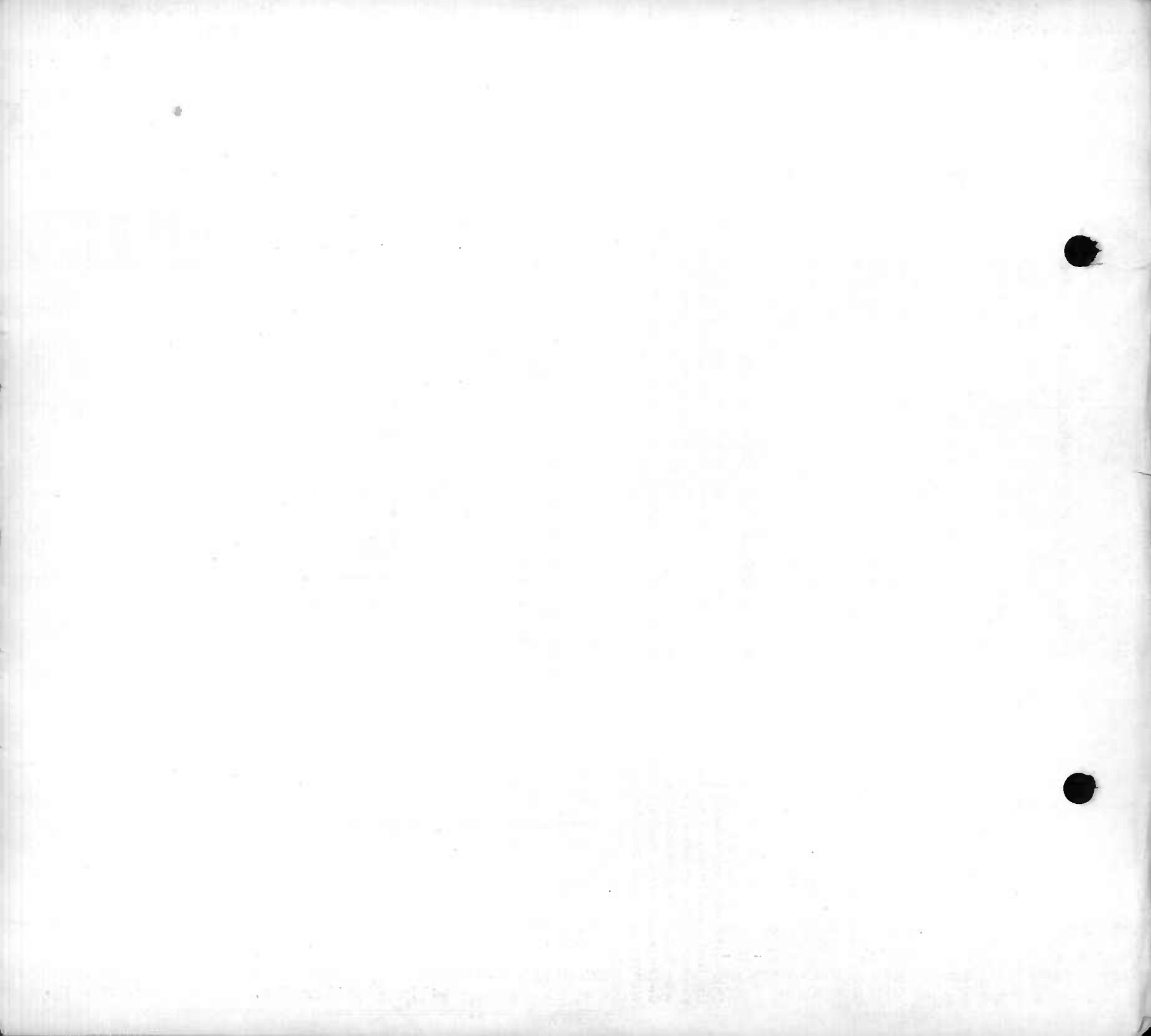


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2555		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2555	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) AGATHA MORGAN		2. DATE AND HOUR OF DEATH MARCH 6, 1965 9:12 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD F B. COUNTY 1-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 31 D. STREET ADDRESS (If rural, give location) 2244 BANK ST			
5. SEX F	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1878 JUNE 8, 1914	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State of foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME GEORGE HUMMER		14. MOTHER'S MAIDEN NAME WALBUEGA NILIES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Kingsley Morgan 2244 Bank Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 15-1X I SHOCK		CAUSE OF DEATH (A) DUE TO Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 7 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO Gastric CARCINOMA (?)		30 minutes	
(C) DUE TO		MONTHS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Cardiovascular Disease years					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 6 (10:25 PM) 65 to MARCH 6 (9:12 PM) 65, that (I) (we) last saw the deceased alive on MARCH 6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. O. Nelson C. Sun		23B. DATE SIGNED 3/6/65			
23C. PHYSICIAN'S NAME (Type) NELSON C. SUN		23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-10-1965		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.	

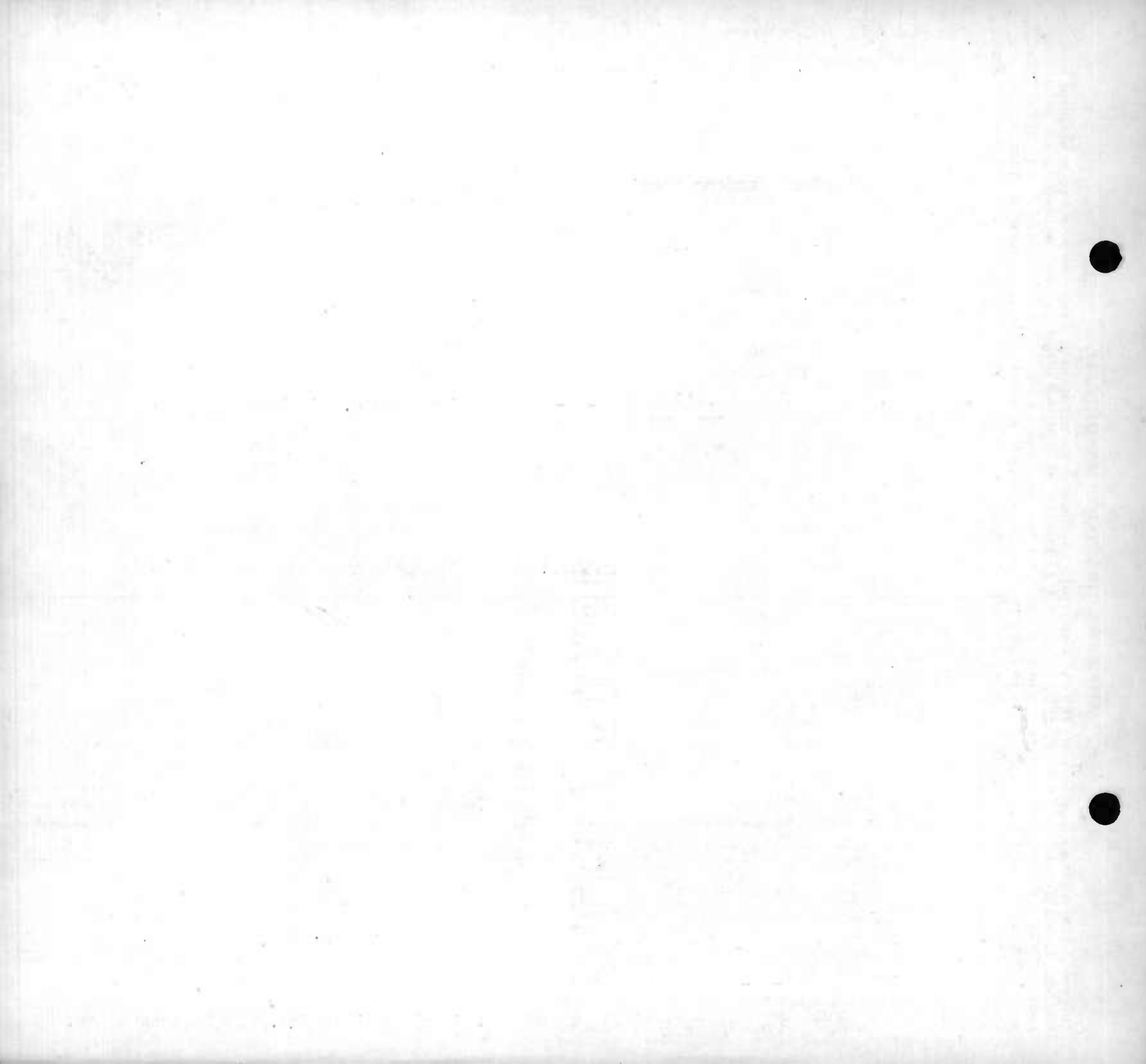




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

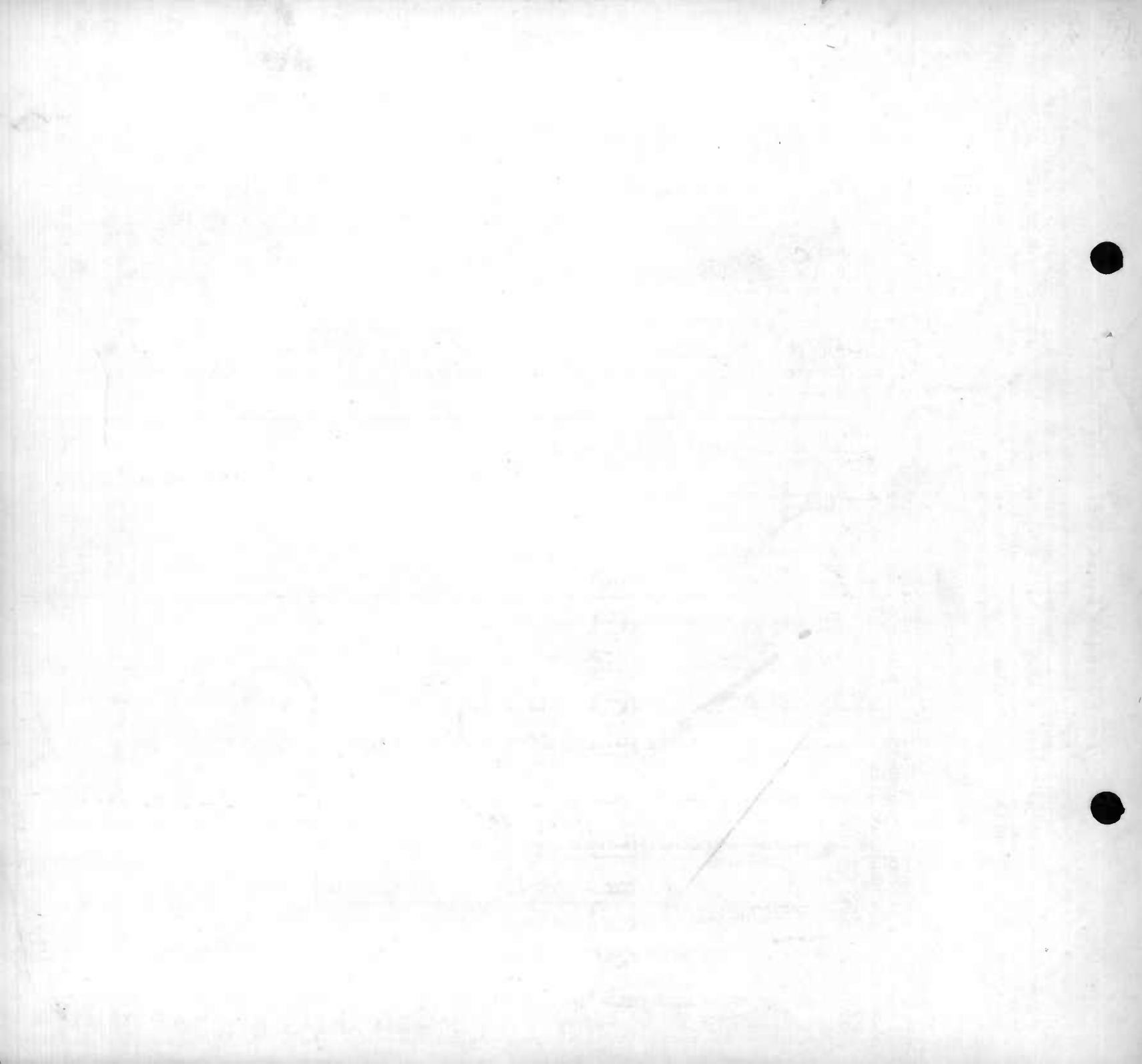
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2556		CERTIFICATE OF DEATH		Registered No. 65 2556	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
CHARLES D. SHEPARD				March 7, 1965 4:50 P.M.		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			
Harford Gardens Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. SEX			
A. STATE		B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)		6. RACE	
Maryland		Baltimore		Dundalk		1731 Manor Road		White	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
Widowed		March 14, 1881		83		Retired Guard			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Kingsport, Tenn.				Unknown		Unknown		Aug 3, 1904 June 30, 1914	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
216-01-9090		Christopher J. Wiechert		1731 Manor Road		(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		12-30-64	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None		None		None		None			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
None		None		None		None		None	
22. I certify that (I) (this hospital) attended the deceased from 12-30-64 19 to Mar 7 1965, that (I) (we) last saw the deceased alive on 3-7-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
		A. G. Schimunek		3-8-65		E. A. SCHIMUNEK		842 SEAST AVE 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.	
Burial		3-10-1965		Glen Haven		Anne Arundel Co., Maryland		MAR 9 1965	
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. ADDRESS			
Blair E. Taylor		Hill & Zeiler Inc.		1901 Eastern Ave.					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-2557		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65-2557	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BABY GIRL ROLAND		2. DATE AND HOUR OF DEATH 2/27/65 9:25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE MD. B. COUNTY 27-12	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of MD.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 428 Hutchins Avenue	
5. SEX F	6. RACE C.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 2-26-65	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: Hours: Min. 1 day
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Joseph S. [unclear]		14. MOTHER'S MAIDEN NAME Carolynne THOMAS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 760.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) 1 Possible Cerebral Hemorrhage. (B) DUE TO (C) 2		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-26-65 1965 to 2-27-65 1965, that (I) (we) last saw the deceased alive on 2-27-65 9:25 PM 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Milan M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) MOKHTAR MILANI	
23D. ADDRESS		23E. FUNERAL DIRECTOR		23F. MORTUARY SERVICE - BCHD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE MAR 2 1965		24C. NAME OF CEMETERY	
24D. LOCATION		24E. CITY, TOWN, OR COUNTY		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. MAR 9 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2558	
BIRTH NO. 30-67-88		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Denton F Ryan</i>		2. DATE AND HOUR OF DEATH <i>3/7/65 11:15AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i>		A. STATE B. COUNTY <i>Md. Spring Grove State Hospital</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Catonsville 53-00</i>			
		D. STREET ADDRESS (If rural, give location)			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, (NEVER MARRIED) WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>Oct. 22, 1902</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None - patient</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John M. Ryan</i>		14. MOTHER'S MAIDEN NAME <i>Fannie L. Hyde</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Chant</i>	
18. <i>293X 1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>Acute pulmonary edema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <i>II to hypervolemia</i>			
		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Acute pulmonary edema - shock</i>			
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>March 6, 8PM 1965</i> to <i>March 7, 11:30 AM 1965</i> , that (I) (we) last saw the deceased alive on <i>3/7/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Henry H. Bohman</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/7/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Henry H. Bohman</i>		M.D. <i>University Hospital</i>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-10-1965</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Olivet</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>	
25C. FUNERAL DIRECTOR <i>G. Howard Strong</i>		ADDRESS <i>3207 W. North Ave</i>			

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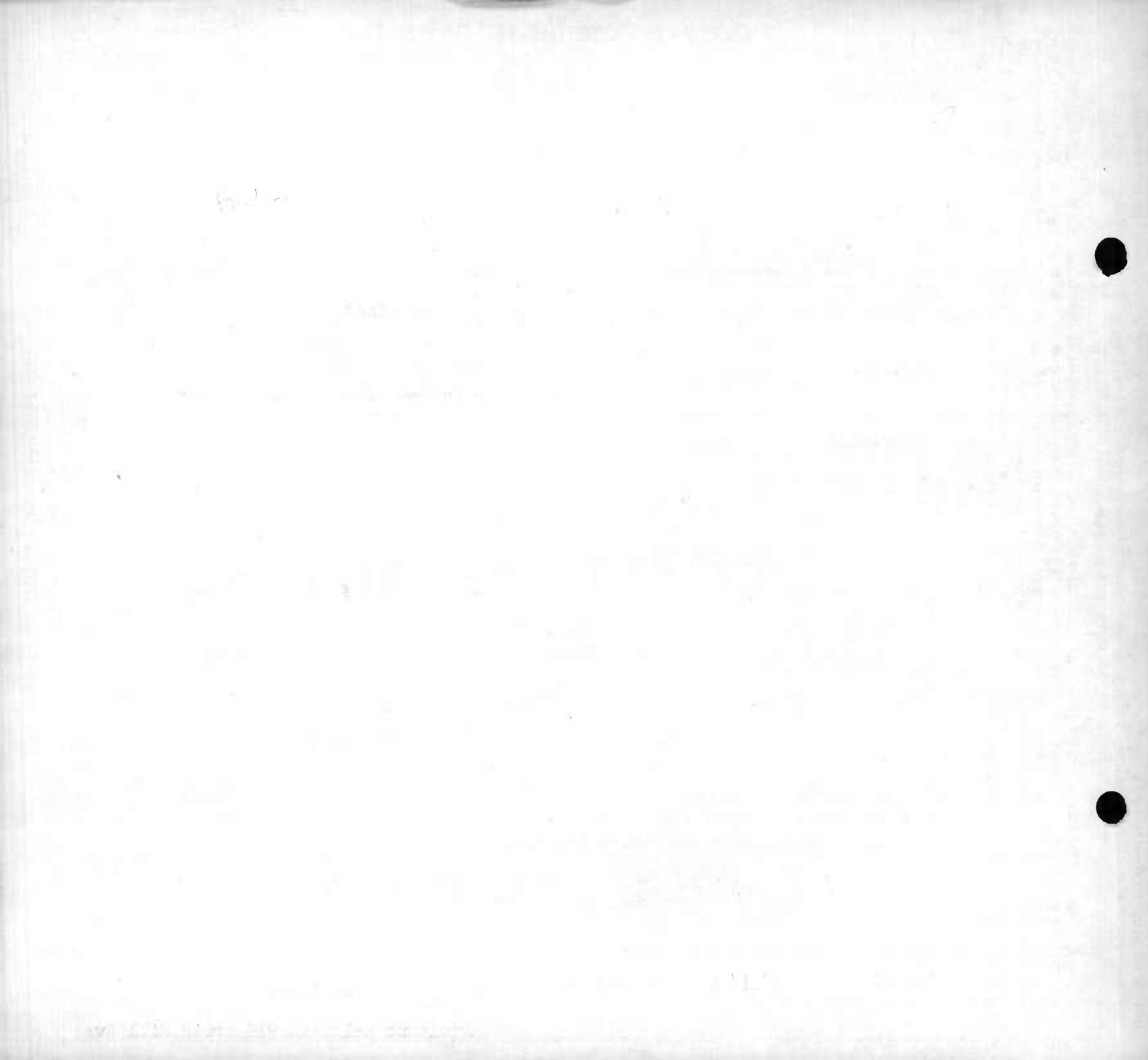
204 (11.11.11)

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2559		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2559	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Arie Gray Thomas		3/5/65		9:25 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Univ of Md.		A. STATE Md		B. COUNTY 17-03	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALT Md #17			
		D. STREET ADDRESS (If rural, give location)			
		1120 Myrtle Ave.			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widow	8. DATE OF BIRTH	9. AGE (In years lost birthday) 80's	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LANDLADY		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr Mathew James Abbot Court	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 400.1 I CAUSE OF DEATH (A) Myocardial Infarction (B) ARTERIOSCLEROTIC C.V.D. (C) INTERVAL BETWEEN ONSET AND DEATH recent LONG STANDING		19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While AT <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/5/65 8pm 1965 to 3/5/65 9pm 1965, that (I) (we) last saw the deceased alive on 3/5/65 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE J Frank Hartman M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/5/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS University Hospital M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/11/65		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION Baltimore Md		24E. DATE REC'D BY HEALTH DEPT. MAR 9 1965		24F. NAME OF REGISTRAR Robert E. Tarkenton	
24G. FUNERAL DIRECTOR Adolphus Halstead		24H. ADDRESS 918 Druid Hill Ave			





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65 2560		BALTIMORE CITY HEALTH DEPARTMENT		65 2560	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
JOHN JACKSON			3-7-65 10:50 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
FRANKLIN SQUARE HOSPITAL - DOA			Maryland 19-02		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			234 N. Gilmore Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	Colored	NEVER MARRIED	AUG 12-1894	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RET. LABORER		SHIPYARD		PRINCE GEORGE CO. VA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
NOAH JACKSON			ELLEN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES W.W.I		228-18-5479		LUCY BUSH 234 N Gilmore St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Pulmonary tuberculosis		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER [ ]		DATE SIGNED	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER [ ]			
PETER W. RIECKERT, M.D.		ASSOCIATE MEDICAL EXAMINER [X]		3-8-65	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial		3/12/1965		Baltimore National	
				Baltimore Md	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
MAR 9 1965		P. E. Taylor, M.D.		H. H. Hays 638 N Gilmore St	

WALTER FOWLER

INDEPENDENT

1954

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 65 2561					
BIRTH NO. 65 2561		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>BAKER, RHODA ANN</b>			2. DATE AND HOUR OF DEATH <b>7:25 PM March 8 1965</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>AA</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Maryland University Hosp.</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>52-00</b>					
D. STREET ADDRESS (If rural, give location) <b>Box 392 Pasadena, Md.</b>										
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>8-24-05</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>PUT FAMILY</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Isaac Pack</b>					14. MOTHER'S MAIDEN NAME <b>Emma Washington</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Edward Baker</b>		ADDRESS <b>CL5-5789</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of cervix</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>					(A) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>congestive heart failure</b> <b>3 days</b>					(B) DUE TO					
					(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month): (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>Feb. 27 1965</b> to <b>March 8 1965</b> , that (I) (we) last saw the deceased alive on <b>March 8 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>Chee Fa Tse</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <b>3-8-65</b>				
23C. PHYSICIAN'S NAME (Type) <b>CHEE FA TSE Chee Fa Tse</b> M.D.						23D. ADDRESS <b>Maryland University Hospital</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burned</b>		24B. DATE <b>3/12/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Zion Methodist</b>			24D. LOCATION (City, town, or county) (State) <b>Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>			25B. NAME OF REGISTRAR <b>Phyllis E. Taylor</b>			25C. FUNERAL DIRECTOR <b>Phyllis E. Taylor</b> ADDRESS <b>638 N. Gilman</b>				

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Put Forward

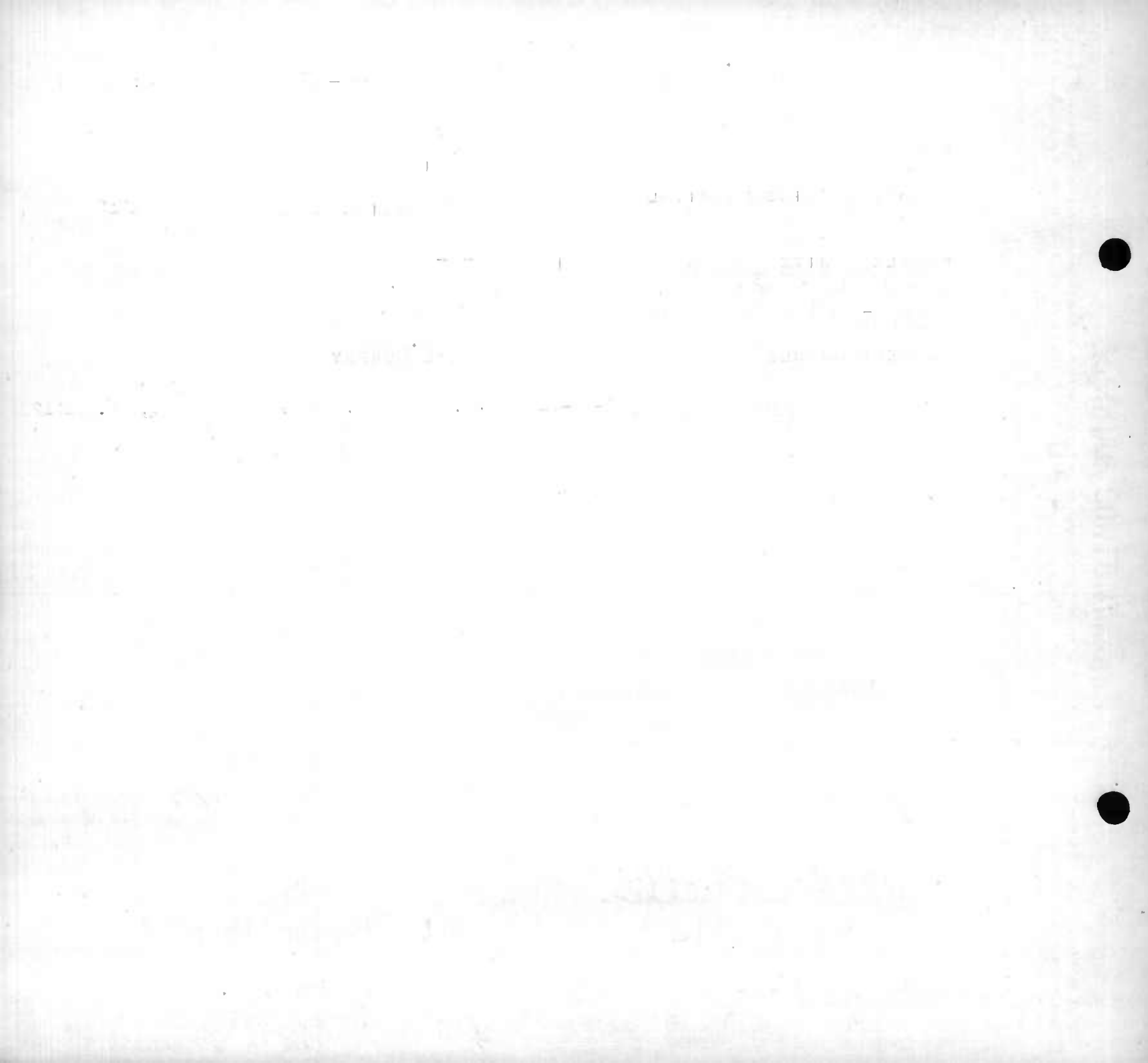
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at the Government Press, Calcutta

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 2562</u>	
BIRTH NO. <u>65 2562</u>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO. <u>M.</u>		2. DATE AND HOUR OF DEATH <u>3-7-65</u> <u>4:30</u> <u>P</u> M.	
1. NAME OF DECEASED (Type or Print) <u>FANCHON KUHNLE</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>JOHNS HOPKINS HOSPITAL</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
		D. STREET ADDRESS (If rural, give location) <u>327 DUNKIRK ROAD</u> <u>21212</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>4-1-97</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Retired</u>	10B. KIND OF BUSINESS OR INDUSTRY <u>Gas and Electric</u>	9. AGE (In years last birthday) <u>67</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
13. FATHER'S NAME <u>JOSEPH KUHNLE</u>		14. MOTHER'S MAIDEN NAME <u>M. ANNE MURPHY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>212-05-7154</u>	
		17. INFORMANT <u>Mrs. Louise K. Clinedinst</u> ADDRESS <u>327 Dinkirk Road</u>	
18. <u>330X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>subarachnoid hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>none</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>none</u>			
19A. DATE OF OPERATION <u>none</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>no</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that <u>it</u> (this hospital) attended the deceased from <u>2/26</u> <u>1965</u> to <u>3/7</u> <u>1965</u> , that <u>it</u> (we) last saw the deceased alive on <u>3/7</u> <u>1965</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) <u>did not</u> view the body after death.			
23A. SIGNATURE <u>M.E. Raichle</u>		23B. DATE SIGNED <u>3/7/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>M.E. Raichle</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>3/10/1965</u>	24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1965</u>	25B. NAME OF REGISTRAR <u>John E. Fisher</u>	25C. FUNERAL DIRECTOR <u>Wm. D. Slickner &amp; Sons</u> ADDRESS <u>North Ave. BALTO. Md. 21217</u>	





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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2563		CERTIFICATE OF DEATH		Registered No. 65 2563	
1. NAME OF DECEASED (Type or Print) <b>Mary E. Thompson</b>						2. DATE AND HOUR OF DEATH <b>March 6, 1965</b> <span style="float: right;">5:30 P.M.</span>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>4310 Springdale Ave.</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2802</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto.</b> D. STREET ADDRESS (If rural, give location) <b>4310 Springdale Ave.</b>			
5. SEX <b>Female</b>		6. RACE <b>Colored</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>		8. DATE OF BIRTH <b>April 23, 1877</b>		9. AGE (In years last birthday) <b>87</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Churchton Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Jacob Hutton</b>						14. MOTHER'S MAIDEN NAME <b>Maria</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Alphonsa Thompson</b> ADDRESS <b>4310 Springdale Av</b>			
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) <b>Hypertensive C. V. disease</b> DUE TO <b>many years</b>		INTERVAL BETWEEN ONSET AND DEATH	
						(B) DUE TO			
						(C) DUE TO			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>The year 1948</b> to <b>Mar 1965</b> , that (I) (we) last saw the deceased alive on <b>Mar 4, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Abram Goldman</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED <b>3/8/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Abram Goldman</b> M.D.						23D. ADDRESS <b>4123 Frederick Ave.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>March 10/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Franklin Chaple Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Churchton Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Staley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		25D. ADDRESS <b>319 N. Schroeder</b>			



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BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 2564		<b>CERTIFICATE OF DEATH</b>		65 2564	
M.E. CASE NO.			DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Daisy Scribner Cole</i>			3/7/65 1 3 <sup>05</sup> P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i>			A. STATE <i>MARYLAND</i> B. COUNTY <i>18-02</i>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>		
			D. STREET ADDRESS (If rural, give location) <i>1047 W. VINE ST</i>		
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>June 10, 1897</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Balto. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Joseph Scribner</i>			14. MOTHER'S MAIDEN NAME <i>Alice ?</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>GRAND DAUGHTER</i>		ADDRESS <i>SAME</i>
18. <i>422.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO <i>ASCVD</i> (B) <i>Chronic BRONCHITIS</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>19 55</i> to <i>3/7 19 65</i> , that (I) (yes) last saw the deceased alive on <i>3/7 19 65</i> and that in (my) (an) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Charles A. Asplen</i>				23B. DATE SIGNED <i>3/7/65</i>	
23C. PHYSICIAN'S NAME (Type) <b>CHARLES A. ASPLEN</b>				23D. ADDRESS <i>University Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<i>Burial</i>		<i>March 11, 1965</i>		<i>St. Auburn Cem. Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>Sheldon ...</i>	
				ADDRESS <i>319 N. ...</i>	

University Hospital  
Winnipeg

Winnipeg  
Calgary  
Albera

Winnipeg  
Calgary  
Albera

Winnipeg  
Calgary  
Albera

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BIRTH NO. <span style="float: right;">65 2565</span>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="float: right;">65 2565</span>	
1. NAME OF DECEASED (Type or Print) <b>Eric Jones</b>				2. DATE AND HOUR OF DEATH <b>March 7, 1965</b> <span style="float: right;">9:00am.</span>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital 1514 Division Street Baltimore, Maryland</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>18-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>508 N. Schroeder Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>3-27-64</b>	9. AGE (In years last birthday) <b>11</b>	II Under 1 Yr. Months Days Hours Min. <b>11</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Reynold Jones</b>				14. MOTHER'S MAIDEN NAME <b>Joan Butler</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>JONES</b> <b>Joan Butler 508 N. Schroeder St.</b>		ADDRESS	
18. <b>491 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Meningitis</b> DUE TO (B) <b>Bronchopneumonia</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>March 6, 1965</b> to <b>March 7, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 7, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Rosario D. Bello</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>March 8, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Rosario D. Bello</b>				23D. ADDRESS M.D. <b>1514 Division Street</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/12/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		ADDRESS <b>11 N. Schroeder St.</b>	

Reynolds Jones

No

Trans Office to Reynold J. S.

General Officer Mr. Johnson

William Johnson

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 2566

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Louella Johnson

2. DATE AND HOUR PRONOUNCED DEAD

3-4-65

7:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1708 Wilkens Ave.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced Jan. 19 1928

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

File Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Montgomery Ward W. Va.

11. BIRTHPLACE (State or foreign country)

W. Va.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Brooker Short

14. MOTHER'S MAIDEN NAME

Wanda Blaire Sister

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

235-38-1131

17. INFORMANT

Mrs Harold Greenhalgh

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Acute Ethylism  
DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Barbiturate overdose

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

?

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

?

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

3

65

?

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

ingestion of alcohol and barbiturates

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

3-5-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/8/65

23C. NAME OF CEMETERY or CREMATORY

Glen Haven

23D. LOCATION

Glen Burrier, Md

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 9 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

W. J. 4101 Edmondson

ADDRESS



TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

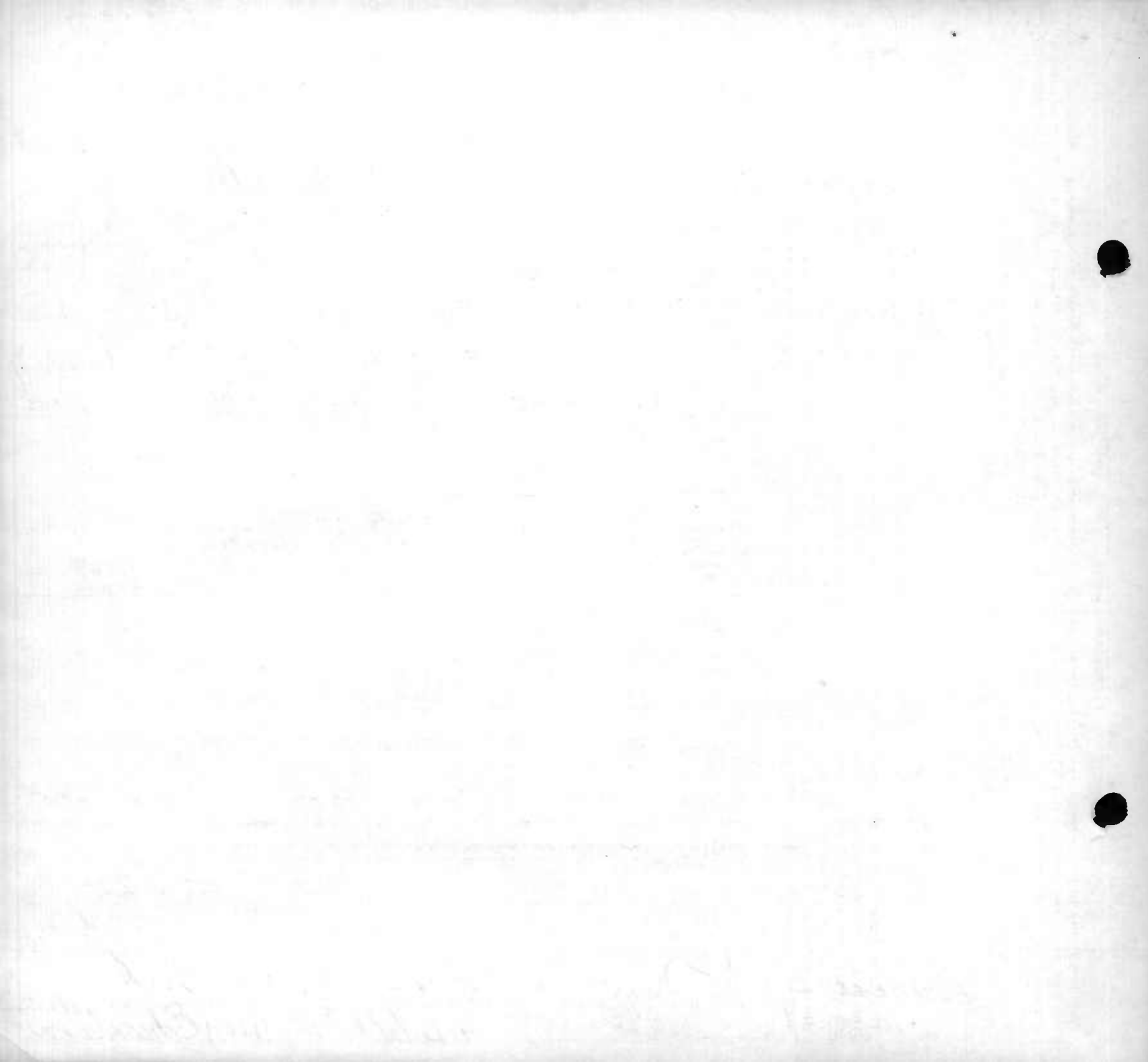
DATE: [illegible]



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 2567					CERTIFICATE OF DEATH				
Registered No. 65 2567									
1. NAME OF DECEASED (Type or Print) <u>Edward D. Ross</u>					2. DATE AND HOUR OF DEATH <u>MARCH 6, 1965</u> <u>7:35P</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived; if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>Md. Genl. Hosp.</u>					A. STATE <u>MARYLAND</u>				
(If not in hospital or institution, give street address or location)					B. COUNTY <u>-</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>				
					D. STREET ADDRESS (If rural, give location) <u>3320 Poplar St.</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>9/10/03</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>T.V. Repairman</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>T.V. Repair</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Ross</u>					14. MOTHER'S MAIDEN NAME <u>Laura DelMoore (Wife)</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>147-05-1175</u>		17. INFORMANT ADDRESS <u>HOSPITAL CHART-Mildred P. Ross</u>				
18. <u>443X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <u>Acute Myocardial Infarct.</u> DUE TO (B) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (C) _____				
INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>5-10 yrs.</u>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>3/6</u> 19 <u>65</u> to <u>3/6</u> 19 <u>65</u> , that (1) <del>was</del> last saw the deceased alive on <u>3/6</u> 19 <u>65</u> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (1) <del>We</del> (did) <del>did not</del> view the body after death.									
23A. SIGNATURE <u>Gerald A. Hotkin</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/6/65</u>		
23C. PHYSICIAN'S NAME (Type) <u>Gerald A. Hotkin</u>					23D. ADDRESS <u>Md. Genl. Hosp. Balto. Md.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>3/10/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Stokely</u>			25C. FUNERAL DIRECTOR <u>W. B. P. 7. D. 401 Edmondson</u>			
						ADDRESS <u>ave</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>10 65 2568</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2568</b>	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>LES, PATRICIA A.</b>			2. DATE AND HOUR OF DEATH <b>3-6-65 9:20 A. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVE. BALTIMORE 29, MARYLAND</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE # 7 53-00</b>		
D. STREET ADDRESS (If rural, give location) <b>1209 DANIELS AVE.</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b> (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>11-6-39</b>	9. AGE (In years lost birthday) <b>25</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JEROME GRACE</b>			
14. MOTHER'S MAIDEN NAME <b>ANNA</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UN.</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>ST. AGNES RECORDS, CATON &amp; WILKENS</b>			
18. <b>332X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Thrombosis, Internal Carotid Artery Left, Spontaneous</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>3/4/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Left Carotid Artery</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 3 1965</b> to <b>MARCH 6 1965</b> , that (I) (we) last saw the deceased alive on <b>MARCH 6 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles M. Henderson</b>				23B. DATE SIGNED <b>3/6/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Charles M. Henderson</b>				23D. ADDRESS <b>803 Cathedral St. Balto. 1, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/9/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md. Ave</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>W. 4101 Edmondson</b>	

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65 2569		BALTIMORE CITY HEALTH DEPARTMENT		65 2569	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
Augusta Klein		March 6, 1965 8:00 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 533 N. Rose Street			
Union Memorial Hospital		702			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Female	White	Widow	Apr. 25 1922	72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Edw. C. Klein		Catherine Hartman		W. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		216015839		Mrs. Audrey Lance E. Elliott City, Md.	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Craniocerebral injury DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
Mar. 4, 1965		head injury		yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		street		Food Fair sidewalk, 2500 blk. E. Monument	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		fell and sustained head injury	
Feb. 19, 1965 A.m.				07-02	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
John E. Adams, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		Mar. 7, 1965	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial		3/10/65		St. Paul's	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
MAR 9 1965		Robert E. Taylor, M.D.		Violetville Park, Md. 4101 Edmondson	

WALTER BOUCE

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Letter 3/1/42 M. G. B. 1/1/42



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <span style="font-size: 2em;">65 2570</span>		<b>CERTIFICATE OF DEATH</b>		65 2570	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GAITHER, TENIE BARBARA		3 5 65 6:45 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  ST AGNES HOSPITAL		A. STATE B. COUNTY MARYLAND			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) CATONSVILLE			
		D. STREET ADDRESS (If rural, give location) 909 KENT AVENUE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: Hours: Min.
FEMALE	WHITE	WIDOWED	7 16 87	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		OWN HOME		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
FLANK SLIVKA			ANTONIA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		219 01 9525		25 ST AGNES HOSP RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <i>Congestive Heart Failure</i>		<i>several hours</i>	
		(B) DUE TO <i>resolving subphonic abscess</i>		<i>weeks</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		YES	YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from FEB 12 19 65 to MARCH 5 19 65, that (we) last saw the deceased alive on MARCH 5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W K Gallagher, Jr</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) W K GALLAGER, JR				23D. ADDRESS ST AGNES HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
BURIAL	3 9 65	MEADOWRIDGE MEMORIAL PK	HOWARD CO., MD		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
MAR 9 1965	<i>Robert E. Staley, Jr</i>	WITZKE F D		54101 EDMONDSON AVE.	

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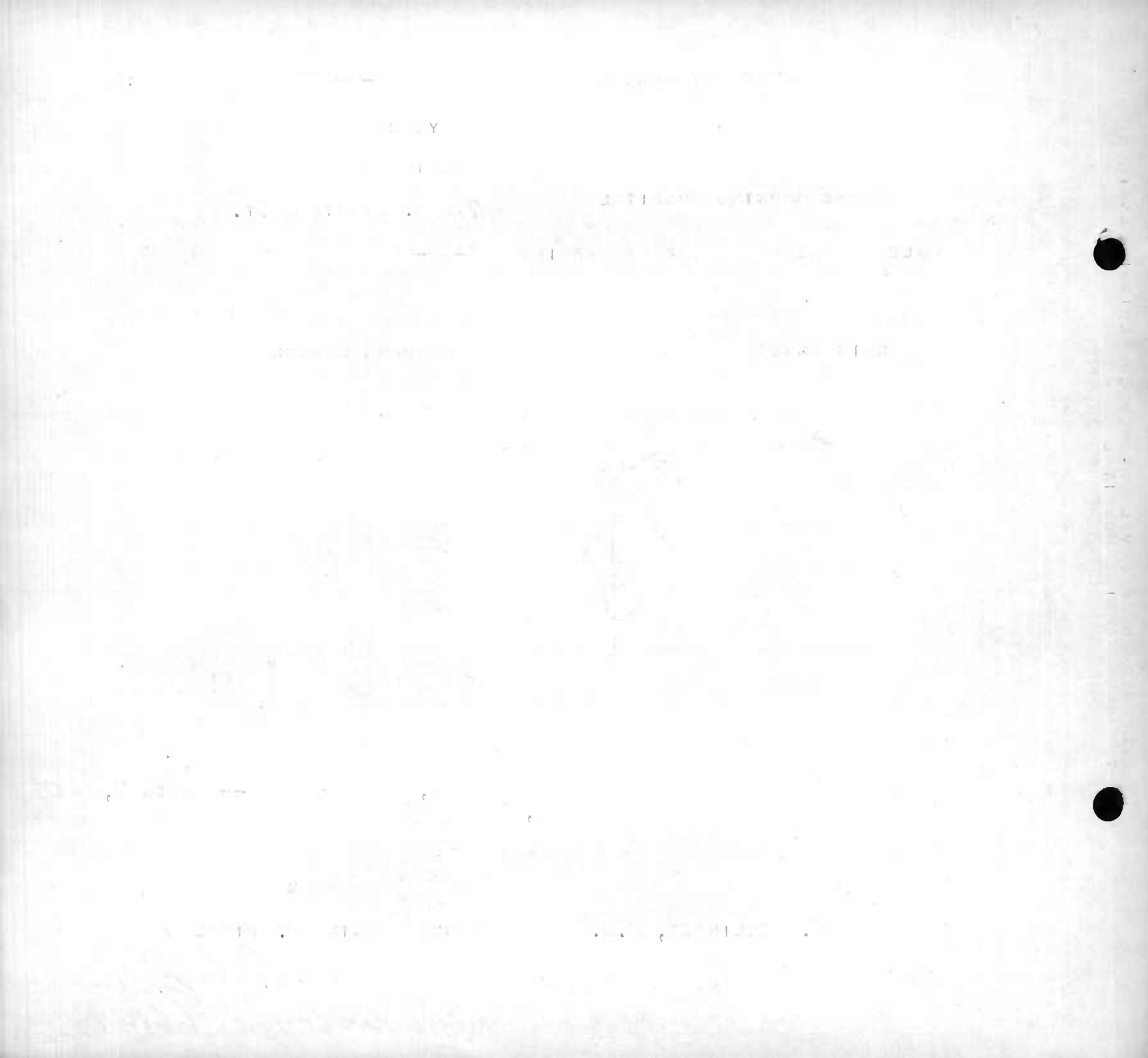
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2571 64-14015		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2571	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JEFFEREY CHANGE		3-7-65		3:00 xP M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
JOHNS HOPKINS HOSPITAL		MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		770 W. SARATOGA ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
MALE	NEGRO	NEVER MARRIED	5-11-64	9	24
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
ENNIS CHANGE		BARBARA LONDON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
340.31		meningitis		?	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				YES	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 7, 1965 to MARCH 7, 1965, that (I) (we) last saw the deceased alive on MARCH 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James F. Mellinger M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) JAMES F. MELLINGER, M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/11/65		Mt Auburn	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
Baltimore Md		Charles A Rice 661 W. Barre			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 9 1965		Robert E. Fairley		Charles A Rice 661 W. Barre	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2572		CERTIFICATE OF DEATH		Registered No. 65 2572	
1. NAME OF DECEASED (Type or Print) <b>Ellie Johnson</b>				2. DATE AND HOUR OF DEATH <b>3/8/65 1:45 AM</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>9-08</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1008 E 20th Street</b>					
5. SEX <b>Female</b> RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>		8. DATE OF BIRTH <b>4/18/17</b>		9. AGE (In years lost birthday) <b>47</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William Bynum</b>				14. MOTHER'S MAIDEN NAME <b>Lula Johnson</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>B-37-12-676</b>		17. INFORMANT <b>William Johnson</b>				ADDRESS <b>1008 E 20th St</b>	
18. <b>157X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) CAUSE OF DEATH <b>Sepsis Shock</b> DUE TO (B) <b>Ble Peritonitis</b> DUE TO (C) <b>Cancer of Pancreas</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>9 months</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Cachexia</b>									
19A. DATE OF OPERATION <b>1/7/5</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bleeding Obstruction</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>2/28</b> 19 <b>65</b> to <b>3/8</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3/8</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Gerald Acker</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/8</b>			
23C. PHYSICIAN'S NAME (Type) <b>DR. GERALD ACKER.</b>				23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>3/11/65</b>		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <b>Wilson N. Carolina</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Galt, M.D.</b>		25C. FUNERAL DIRECTOR <b>Yonah T. Elickson</b> ADDRESS <b>1129 N. Calhoun St</b>					

Johns Hopkins Hospital

4/18/97  
7th

Wash D.C.

2013-14

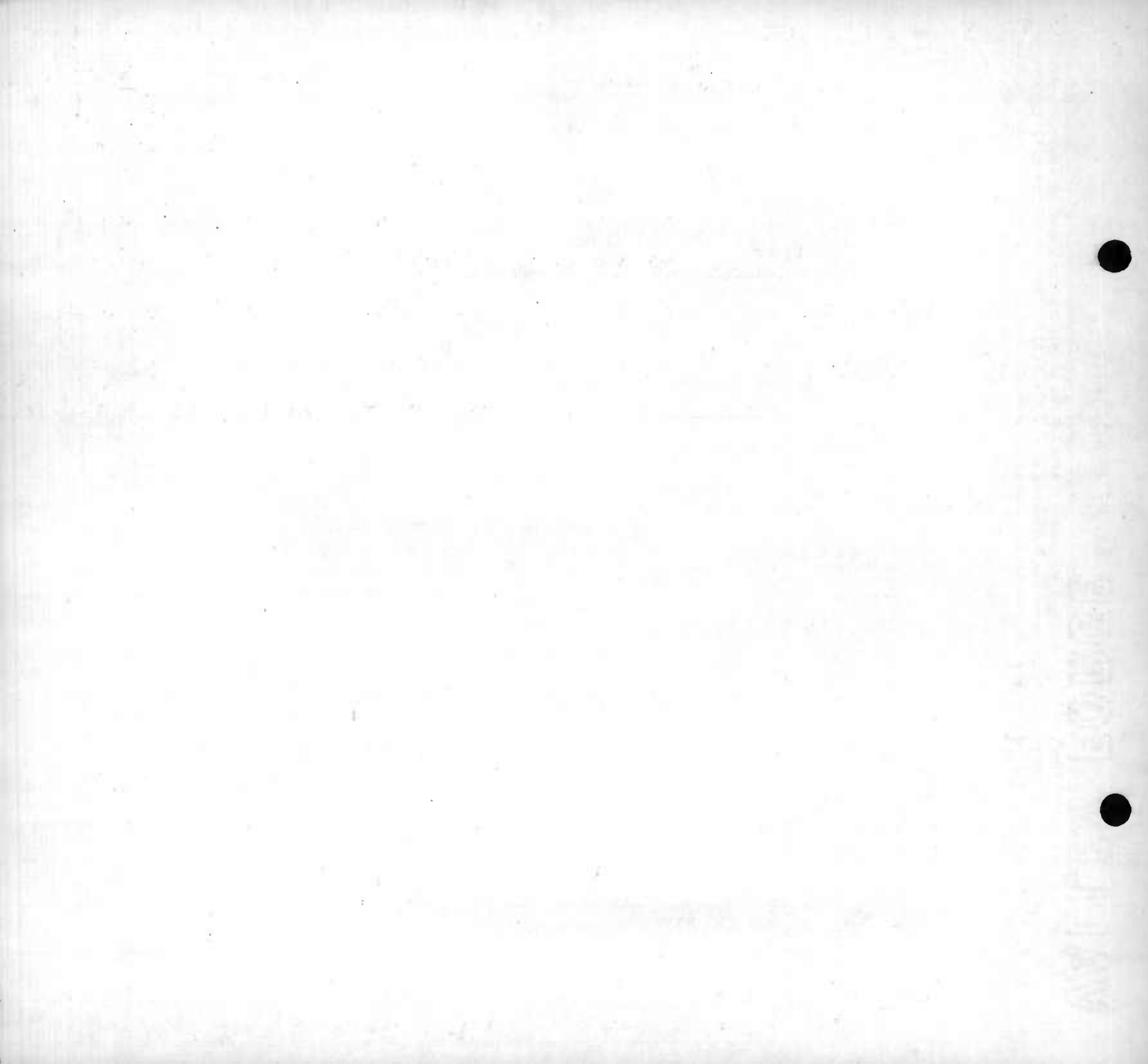
Form: 3/1/12

William M. Cantor  
President of Johns Hopkins

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2573</u>	
BIRTH NO. <u>65 2573</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JOHNSON, MAGGIE</u>		2. DATE AND HOUR OF DEATH <u>3-6-65</u>   <u>2:50 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-04</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>LUTHERAN HOSPITAL OF MD. BALTIMORE 16, Md.</u>		D. STREET ADDRESS (If rural, give location) <u>2133 N. Pulaski St.</u>			
5. SEX <u>F</u>	6. RACE <u>COLORED</u>	7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	B. DATE OF BIRTH <u>10/15/1888</u>	9. AGE (In years lost birthday) <u>76</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Part. Family</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Barley Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Cora Barnes</u>		17. INFORMANT <u>Rev. Ruth Neal - 2130 N. Pulaski St.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		ADDRESS	
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HEART FAILURE.</u>		CAUSE OF DEATH (A) <u>CONGESTIVE HEART FAILURE.</u> (B) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE.</u> (C) <u>URZEMIA.</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>2-12-65</u> 19 to <u>3-6-65</u> 19, that <u>(X)</u> (we) last saw the deceased alive on <u>3-6-65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>BOK Soo Kim</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3-6-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>BOK SOO KIM</u>		23D. ADDRESS <u>LUTHERAN HOSPITAL OF MD, BALTIMORE 16</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>3/11/65</u>	24C. NAME of CEMETERY or CREMATORY <u>Int. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Smith</u>		25C. FUNERAL DIRECTOR <u>Robert E. Smith - 3035 W. North Ave.</u>	



LS: 42-27-98  
J-27-98

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2574				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 2574	
1. NAME OF DECEASED (Type or Print) <b>Sarah<sup>E</sup> Jackson</b>				2. DATE AND HOUR OF DEATH <b>March 6, 1965 10:00 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2438 Francis Street 21217</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8-12-00</b>		9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia - Gloucester Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Grandison</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Leman</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS. <b>RECORDS: BCH: 4940 Eastern Avenue #21224</b>			
18. <b>15381</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma Metastatic</b> (A) DUE TO  ANTECEDENT CAUSES <b>Carcinoma of Colon</b> (B) DUE TO  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) _____				INTERVAL BETWEEN ONSET AND DEATH <b>6 Years</b>  <b>6 Years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>February 16, 1965</b> to <b>March 6, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 6, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dr. Douglas G. Carroll</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>March 6, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Douglas G. Carroll</b>				23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland #24</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/10/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Bethel Baptist Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Gloucester Co Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>		25B. NAME OF REGISTRAR <b>R. E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter 3035 W. North Ave</b>			





1  
C-636

65 2575

BALTIMORE CITY HEALTH DEPARTMENT

65 2575

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EMILY CARTER

2. DATE AND HOUR PRONOUNCED DEAD

March 4, 1965

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

550 Lanvale St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

July 2, 1888

9. AGE (in years  
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Clerk - Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Fresley L. Carter

14. MOTHER'S MAIDEN NAME

Lucinda Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Howard B. Carter 2040 Pentagon St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, osthenio, etc. It means the disease,  
injury or complication which caused death.)

(A) Subdural hemorrhages  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

McMechen St. at Druid Hill Avenue

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)  
2 28 651:15p.m.

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Involved in auto-auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-4-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/8/65

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 9 1965

24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

Robert E. Hutter 3035 W. North Ave

ADDRESS

V83-4.2

Leaf 946

Richard

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

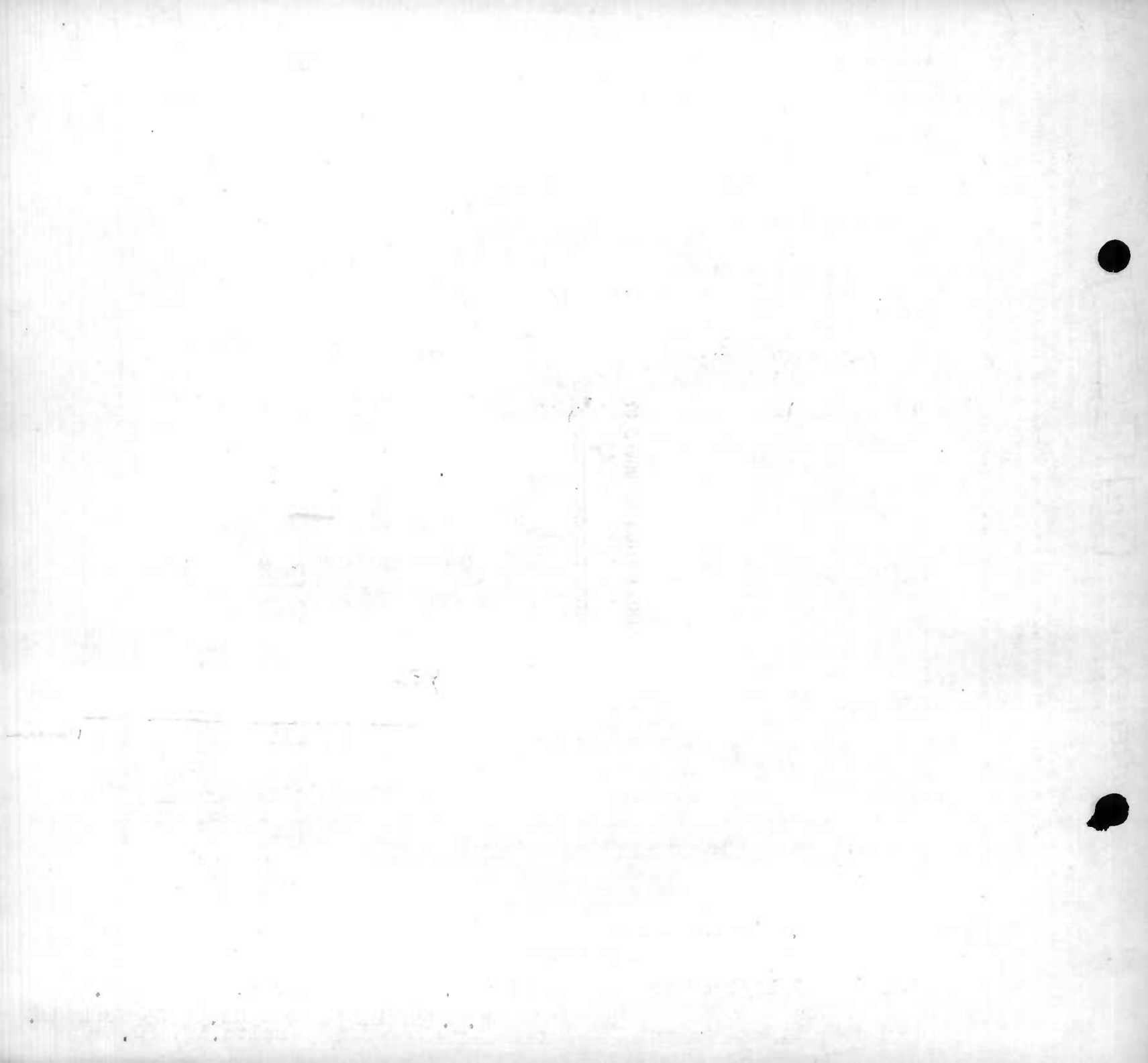
BIRTH NO. 65 2576		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2576	
M.E. CASE NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH 3-8-65 11:45 P.M.	
1. NAME OF DECEASED (Type or Print) REBEKAH OBER THOMAS		2. DATE AND HOUR OF DEATH 3-8-65 11:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL 33RD & CALVERT STS, BALT 18, Md.		A. STATE MARYLAND B. COUNTY BALTIMORE			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH 2/19/96		9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GUSTAVUS OBER	
14. MOTHER'S MAIDEN NAME BESSIE HAMBLETON		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-46-3914	
17. INFORMANT R. L. THOMAS		ADDRESS ABOVE		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) GENERALIZED ATHEROSCLEROSIS YEARS					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. RUPTURED ABD. AORTIC ANEURYSM - 1 DAY					
19A. DATE OF OPERATION 3-8-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURED AORTIC ANEURYSM		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-7-65 19 65 to 3-8-65 19 that (I) (we) last saw the deceased alive on 3-8-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. C. THOMPSON		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-8-65	
23C. PHYSICIAN'S NAME (Type) R. C. THOMPSON		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-10-65		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION Pikesville		24E. STATE Md.		24F. DATE REC'D BY HEALTH DEPT. MAR 9 1965	
24G. NAME OF REGISTRAR Robert E. Jenkins		24H. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd.			



MEDICAL EXAMINER NOTIFIED BY MR. DELO  
RELEASED ON APPROVAL BY MR. DELO  
FUNERAL DIRECTOR IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2577		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2577	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CORCO RAN Celeste Edna		2. DATE AND HOUR OF DEATH 3-7-65 645 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hosp.		A. STATE MARYLAND B. COUNTY BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #10			
		D. STREET ADDRESS (If rural, give location) UNIV. PKWY & 39th St Broadview Apt-521			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 9/10/1899	9. AGE (In years (lost birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY BEAUTICIAN		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? AMERICAN (USA)		13. FATHER'S NAME ROBERT E. PHIPPS (D)		14. MOTHER'S MAIDEN NAME ALVINA FIEGE (D)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 3-3-3461		17. INFORMANT ADDRESS (12) CHARLES M. PHIPPS, 6500 LOCH HILL RD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH CVA (left) FRACTURED Right hip. Coronary art. Thrombosis right, recent		INTERVAL BETWEEN ONSET AND DEATH Last 12 H Approx 2-3 wks.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) APPROXIMATELY 23 wks ago Home	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) ? EXACT DATE UNKNOWN		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL IN BATH ROOM.	
22. I certify that (I) (this hospital) attended the deceased from 3-6-1965 to 3-7-1965, that (I) (we) last saw the deceased alive on 3-7-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Steven Kopits		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-7-65	
23C. PHYSICIAN'S NAME (Type) Dr. Steven Kopits		23D. ADDRESS The Union Memorial Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/10/1965		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION Baltimore, Md.		24E. NAME OF REGISTRAR Robert E. Jenkins		24F. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

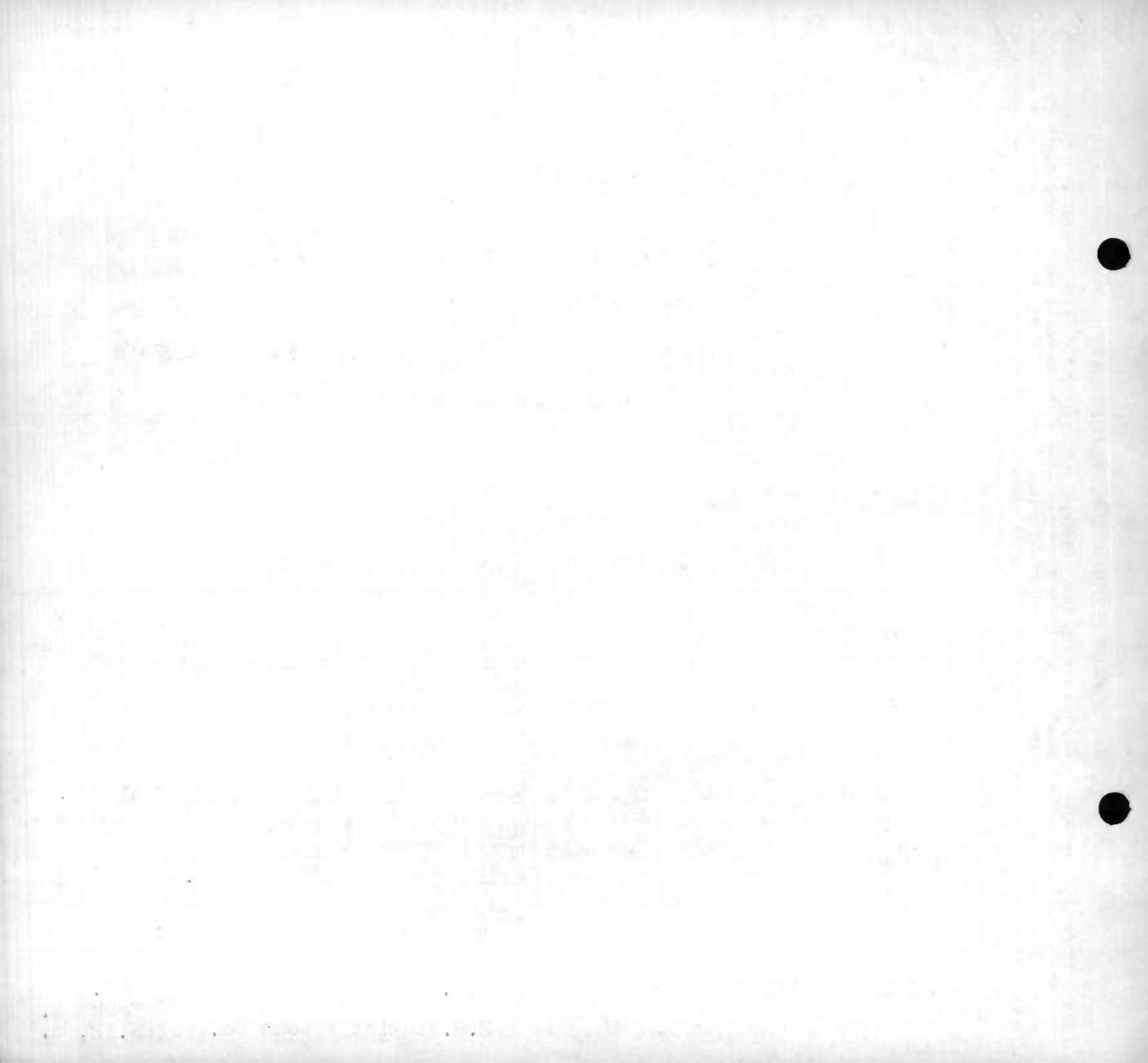




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2578	
BIRTH NO. 65 2578					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Barry, Dolores Keating			2. DATE AND HOUR OF DEATH March 7, 1965 3 35 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5009 Boxhill Lane		
5. SEX F	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-26-22	9. AGE (In years last birthday) 42	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswe.		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Raymond M. Keating			12. CITIZEN OF WHAT COUNTRY? USA.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219-16-4948		17. INFORMANT ALFRED W. BARRY, JR. (SAME)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH (A) DUE TO Lower nephron nephrosis bilateral (B) DUE TO (C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 6, 1965 to March 7, 1965, that (I) (we) last saw the deceased alive on March 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodney L. Brimhall M.D.			23B. DATE SIGNED March 7, 1965		
23C. PHYSICIAN'S NAME (Type) Rodney L. Brimhall			23D. ADDRESS Union Memorial Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/10/65		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION Baltimore, Md.		24E. NAME OF CEMETERY or CREMATORY Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 9 1965		25B. NAME OF REGISTRAR R. L. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. Balto. 12, Md.	



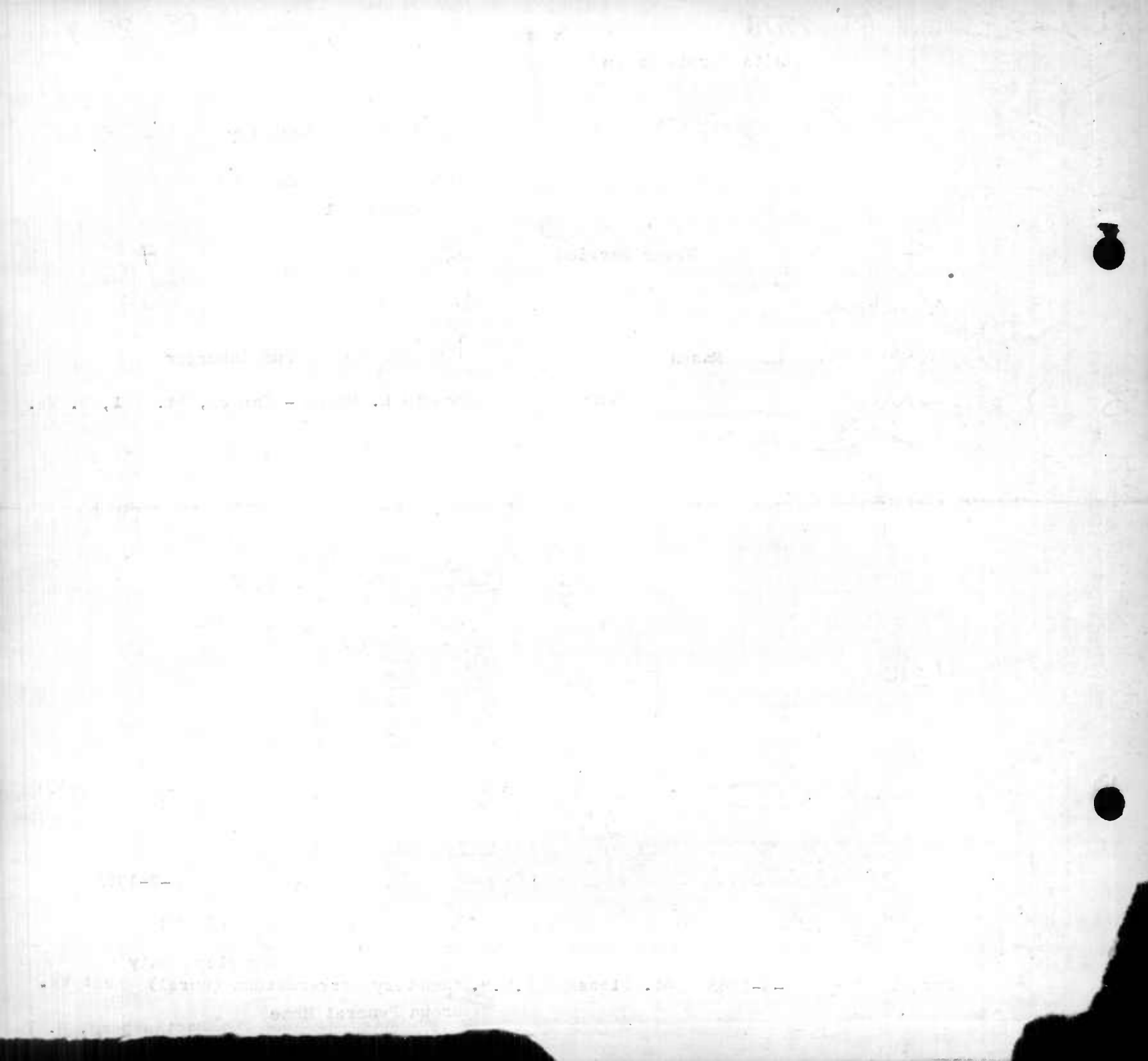


Dr. John Adams of M.E. of prior release body at 11:15 AM 3/6/65

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Baltimore City Health Department	
BIRTH NO. 65 2579		CERTIFICATE OF DEATH		Registered No. 65 2579	
M.E. CASE NO.		1. NAME OF DECEASED Anita Carole Mason Anita Mason		2. DATE AND HOUR OF DEATH 10:55 PM 3/6/65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND SINAI HOSP of Balto FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE West Virginia B. COUNTY Berkeley C. CITY OR TOWN INWOOD W. Va V-45 D. STREET ADDRESS (If rural, give location) Route # 1			
5. SEX 7	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, Never Married	8. DATE OF BIRTH 3/2/65	9. AGE (In years last birthday) 4	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New born		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Va	
13. FATHER'S NAME Kenneth L Mason		14. MOTHER'S MAIDEN NAME Ruby L. Puffinburger			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Kenneth L. Mason - Inwood, Rt. # 1, W. Va.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO Congestive Heart Failure		24 hr	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Pneumonia		36 hr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) Congenital Heart D's.		4 days	
19A. DATE OF OPERATION 3-6-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TE fistula		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/3/19 65 to 3/6/19 65, that (I) (we) last saw the deceased alive on 3/6/65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE S. Seidman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-7-1965	
23C. PHYSICIAN'S NAME (Type) S. SEIDMAN		23D. ADDRESS SINAI Hosp of Balto			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-8-1965		24C. NAME OF CEMETERY or CREMATORY Mt. Pleasant E.U.B. Cemetery Gerrardstown (Rural) West Va.	
24D. LOCATION Berkeley County		25A. DATE REC'D BY HEALTH DEPT. MAR 9 1965			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Brown Funeral Home			
25D. ADDRESS		Martinsburg, W. Va			



# FUNERAL DIRECTOR: IMPORTANT

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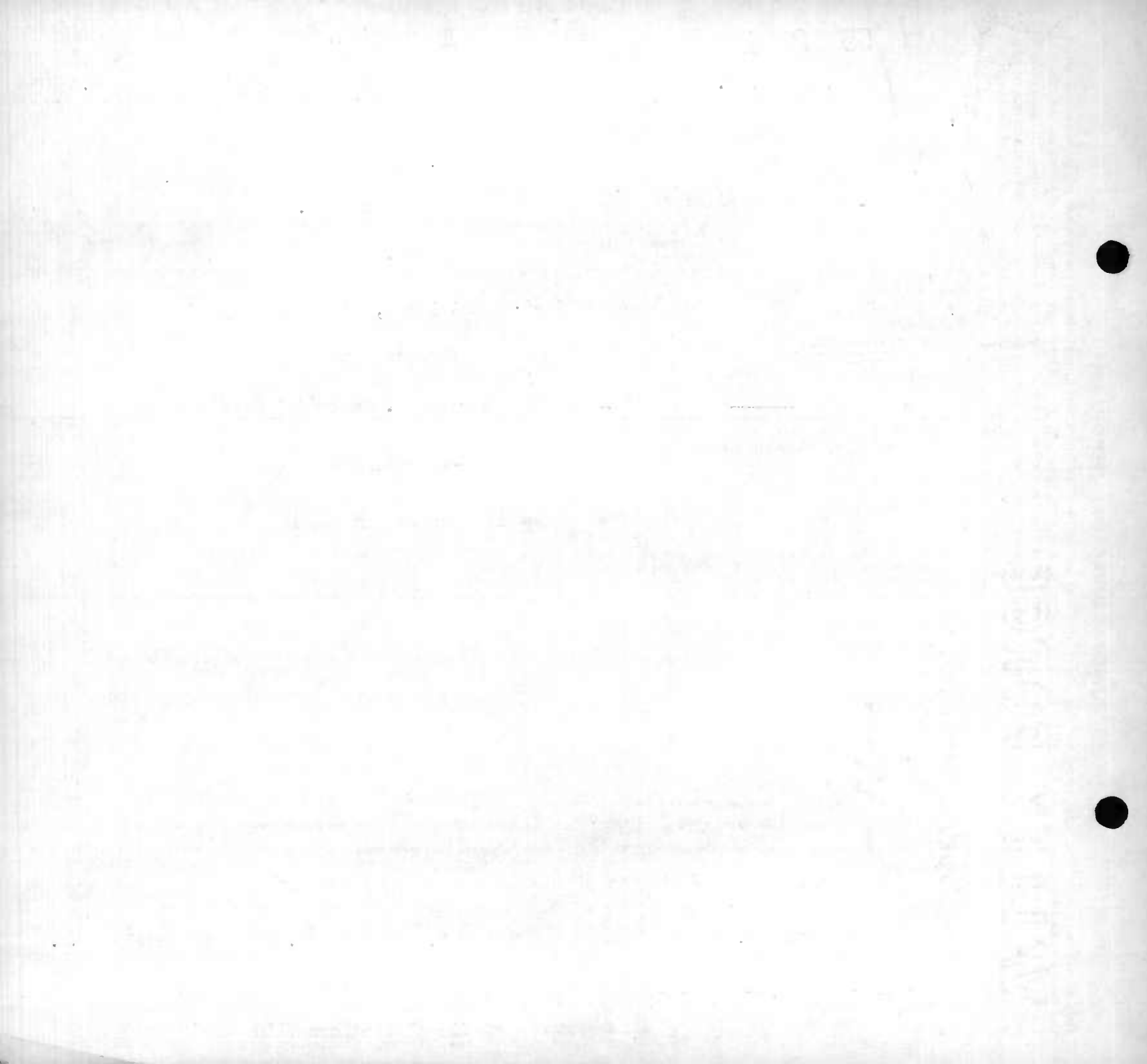
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2580	
BIRTH NO. 65 2580		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Joseph Schwarzkopf		2. DATE AND HOUR OF DEATH 3/7/65 1 10 a. m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lake Drive Nursing Home		A. STATE Maryland B. COUNTY 202			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 222 S. Durham St.			
5. SEX male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 11-12-1902	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10B. KIND OF BUSINESS OR INDUSTRY BALTO CITY HIGHWAY DEPT		11. BIRTHPLACE (State or foreign country) BALTIMORE MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John A. SCHWARZKOPF		14. MOTHER'S MAIDEN NAME ROSE BROWN SEIPPEL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-40-8507		17. INFORMANT TERESA C KUNNECKE 1835 E FAYETTE ST	
18. 334 X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Cardiovascular Cerebrovascular disease		INTERVAL BETWEEN ONSET AND DEATH 200 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-19-1963 to 3/7-1965, that (I) (we) last saw the deceased alive on 3/4-1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis V. Blum, M.D.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/9/65	
23C. PHYSICIAN'S NAME (Type) Louis V. Blum		23D. ADDRESS 3502 W. Rogers Ave Balt. 15, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/65		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER CEM.	
24D. LOCATION 4430 BELAIR RD MD		24E. DATE REC'D BY HEALTH DEPT. MAR 9 1965		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. FUNERAL DIRECTOR		24H. ADDRESS 1800 E LOMBARD ST			



# FUNERAL DIRECTOR: IMPORTANT

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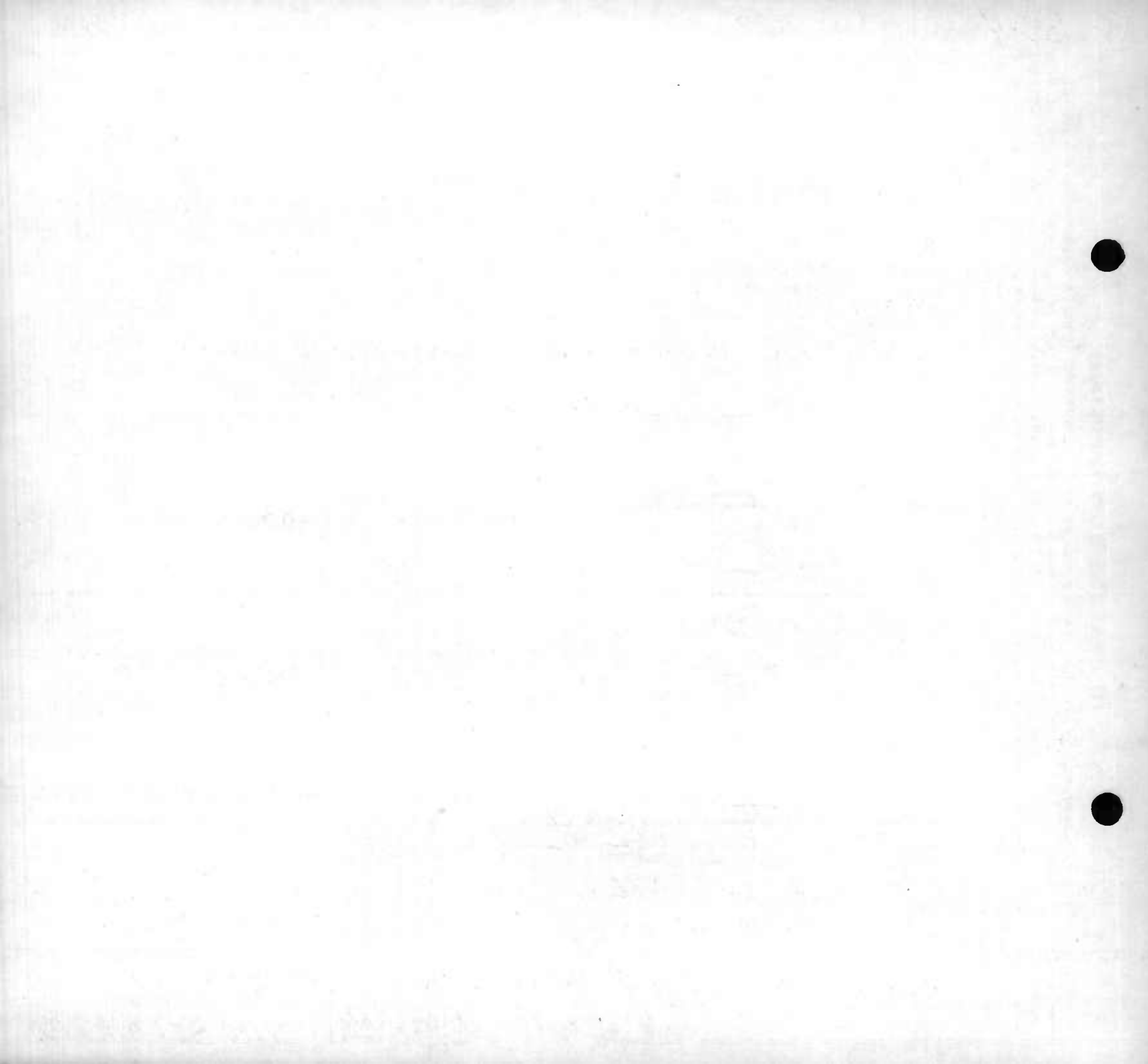
BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>65 2581</u>
BIRTH NO. <u>65 2581</u>		<b>CERTIFICATE OF DEATH</b>				
1. NAME OF DECEASED (Type or Print) <u>Mank, Edward James</u>			2. DATE AND HOUR OF DEATH <u>March 7 1965</u> <u>5.05P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <u>St. Joseph Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #6</u> C. STREET ADDRESS (If rural, give location) <u>6704 Beech Ave.</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>May 29 1896</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Gas &amp; Electric Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			13. FATHER'S NAME <u>Henry Mank</u>			
14. MOTHER'S MAIDEN NAME <u>Theresa Keen</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>212-05-5549</u>			17. INFORMANT <u>Dorothy M. Mank 6704 Beech Avenue</u>			
18. <u>332X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Cerebro-vascular Thrombosis</u> DUE TO (B) <u>Basilar Artery Thrombosis</u> DUE TO (C) _____			
INTERVAL BETWEEN ONSET AND DEATH						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>February 28</u> 19 <u>65</u> to <u>March 7</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>March 7</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>Rostom D. Rivera</u> M.D.			23B. DATE SIGNED <u>March 7 1965</u>			
23C. PHYSICIAN'S NAME (Type) <u>Rostom D. Rivera</u>			23D. ADDRESS <u>1400 N. Caroline St. Baltimore 21213 Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Mar 11 65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>		
24D. LOCATION (City, town, or county) (State) <u>4430 Belair Road Md</u>						
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Staley</u>		25C. FUNERAL DIRECTOR <u>Doppel Brothers 7110 Belair Road</u>		



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2582		CERTIFICATE OF DEATH		Registered No. 65 2582	
1. NAME OF DECEASED (Type or Print) <b>RUTZLER, EDWARD A.</b>				2. DATE AND HOUR OF DEATH <b>MAR 7, 1965 6:30 A</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>U.S.P.H.S. HOSP. BALTO. MD.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO</b> D. STREET ADDRESS (If rural, give location) <b>30 40 FLEET WOOD AVE</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MAR.</b>	8. DATE OF BIRTH <b>10-30-87</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MMI</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>		11. BIRTHPLACE (State or foreign country) <b>FRANCE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
13. FATHER'S NAME <b>EUGENE RUTZLER</b>				14. MOTHER'S MAIDEN NAME <b>KATHERINE RUSTERHOLD</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 1908-1939</b>		16. SOCIAL SECURITY NO. <b>213-014176</b>		17. INFORMANT <b>HOSP. CHART</b>		ADDRESS			
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY EMBOLUS</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>				(A) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CARCINOMA BLADDER</b> about 3 mos.				(B) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <u>it</u> (this hospital) attended the deceased from <u>JAN 4</u> 19 <u>65</u> to <u>MAR 7</u> 19 <u>65</u> , that <u>it</u> (we) last saw the deceased alive on <u>MAR 7</u> 19 <u>65</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>it</u> (we) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Frank A. Bartkus</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>MAR 7, 1965</b>			
23C. PHYSICIAN'S NAME (Type) <b>FRANK A. BARTKUS</b> M.D.				23D. ADDRESS <b>USPHS HOSP. BALTO</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>MAR 10 65</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTO NATIONAL CEM</b>		24D. LOCATION (City, town, or county) (State) <b>FREDERICK RD MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Adolph B. 7110 BELAIR RD</b>					

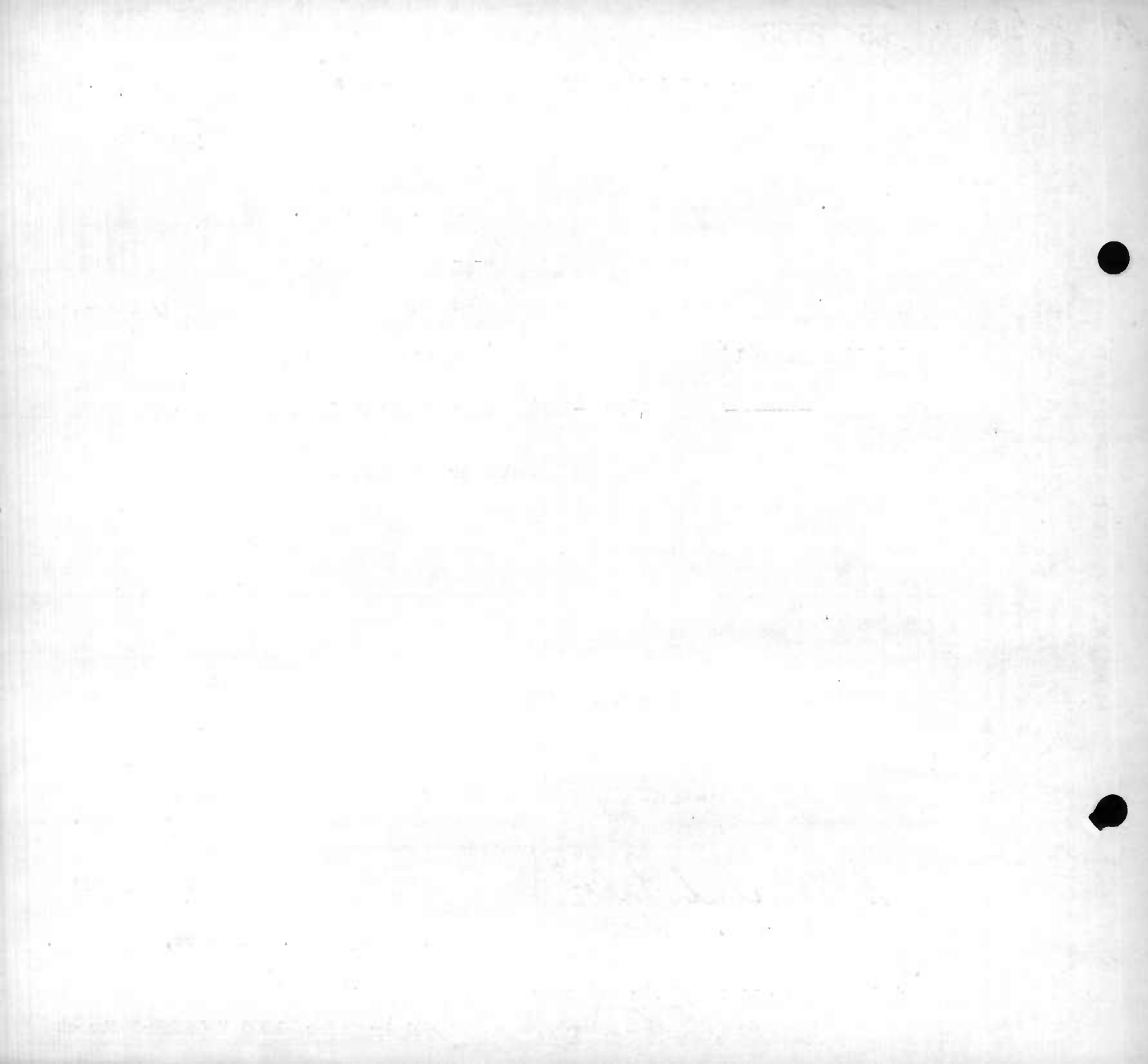




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

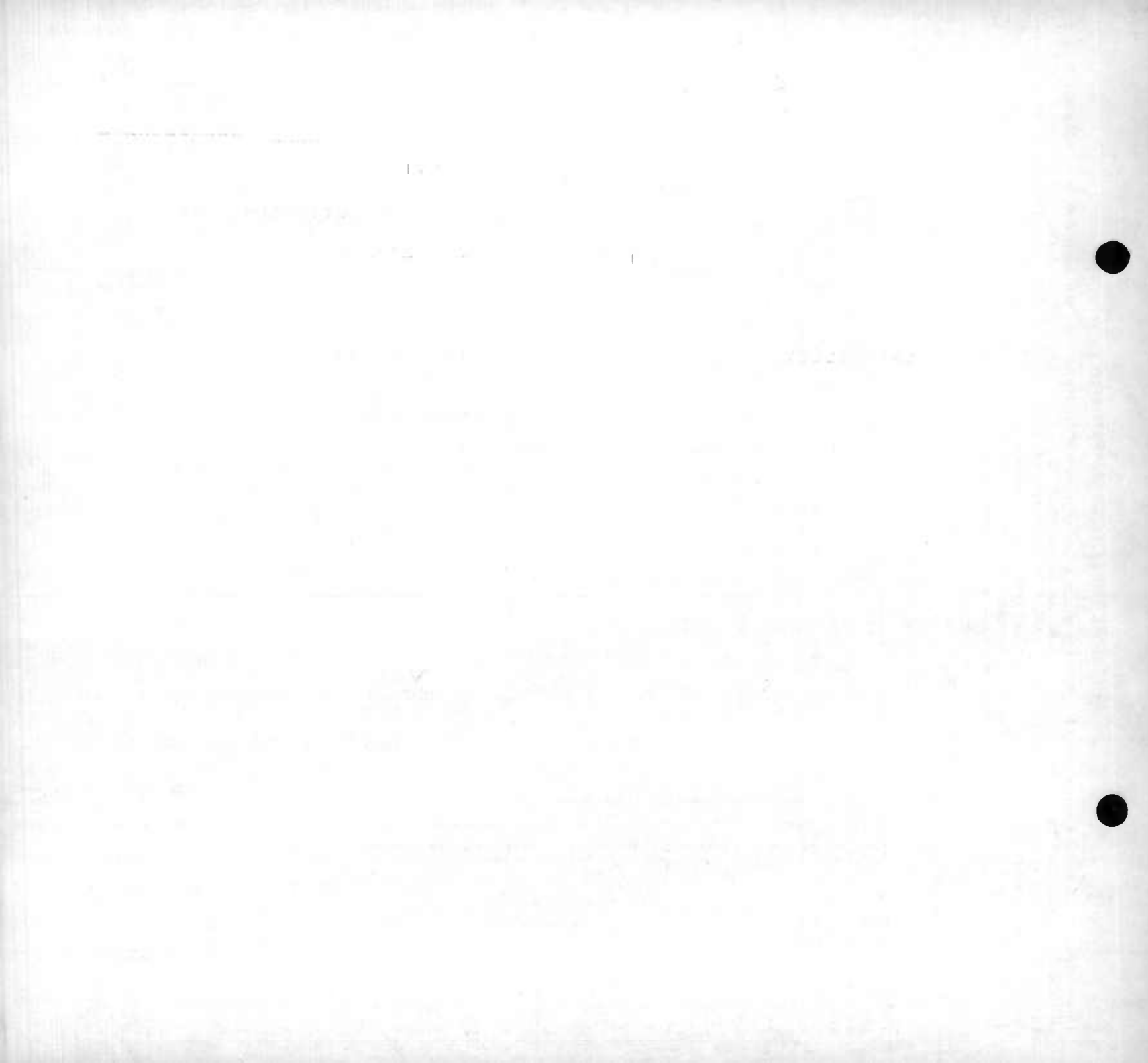
BIRTH NO. <b>65 2583</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2583</b>	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Moser, Max or Maximillian 11</b>			2. DATE AND HOUR OF DEATH <b>March 7 1965 8.10P M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Joseph Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>201</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #31</b> D. STREET ADDRESS (If rural, give location) <b>116 S. Castle St.</b>		
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>8-2-99</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Esskay</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>Maximillian Moser 1</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>213-05-2436</b>		
17. INFORMANT <b>Theresa Moser 116 S Castle Street</b>			ADDRESS		
18. <b>527.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary emphysema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>Pulmonary emphysema</b> DUE TO (B) <b>None</b> DUE TO (C) <b>None</b>		
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Yes</b>		
20A. AUTOPSY? (Yes or No) <b>Yes</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>February 23 19 65</b> to <b>March 7 19 65</b> , that (I) (we) last saw the deceased alive on <b>March 7 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William B. VandeGrift</b>			23B. DATE SIGNED <b>March 8, 1965</b>		
23C. PHYSICIAN'S NAME (Type) <b>William B. VandeGrift</b>			23D. ADDRESS <b>1400 N. Caroline St. Baltimore, 21213 Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Mar 11 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>4430 Belair Road Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Dippel Brothers 1800 E Lombard Street</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

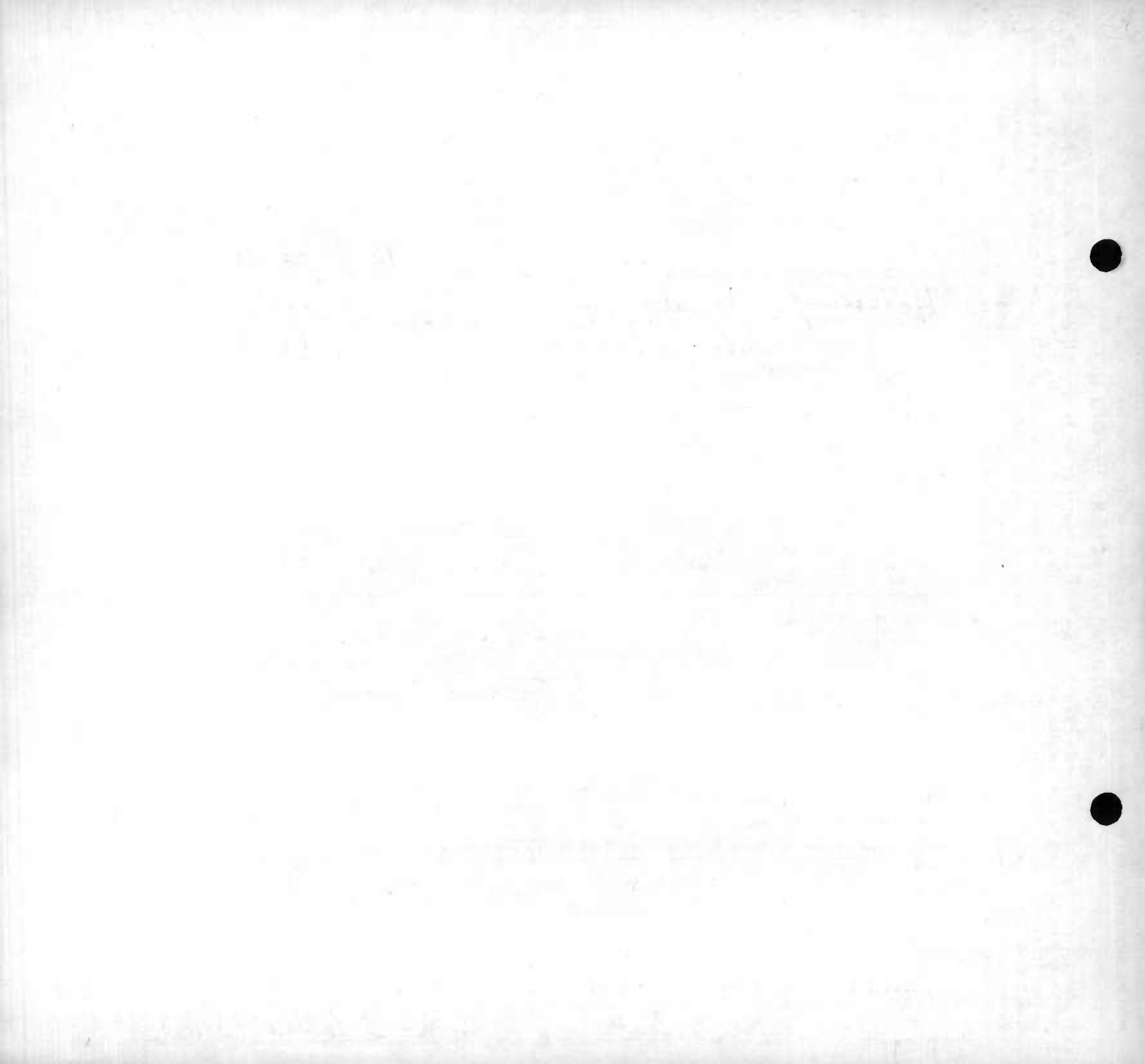
BIRTH NO. 65 2584		BALTIMORE CITY HEALTH DEPARTMENT		65 2584	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <i>Nace, HILDA</i>		2. DATE AND HOUR OF DEATH <i>At 8:5 am, March-7, 1965 8:00 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Buttercup Lane</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE Balto</i> D. STREET ADDRESS (If rural, give location) <i>16 BUTTERCUP LANE 3300</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>4-10-13-09</i>	9. AGE (In years last birthday) <i>55</i>	If Under 1 Yr. Months: Oys: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>		11. BIRTHPLACE (State or foreign country) <i>Ind.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>RALPH KELLEY</i>		14. MOTHER'S MAIDEN NAME <i>SUSAN LEACH</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mr. James Nace 3643 Cottage Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>170X I</i>		CAUSE OF DEATH <i>Right parietooccipital brain tumor, probably metastasis from breast cancer, for 3 months</i>		INTERVAL BETWEEN ONSET AND DEATH <i>December 1964</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2-5-65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Right brachioarteriogram</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2-3-1965</i> to <i>3-7-1965</i> , that (I) (we) last saw the deceased alive on <i>3-7-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Sumio Uematsu</i> M.D.		23B. DATE SIGNED <i>3-7-1965</i>		23C. PHYSICIAN'S NAME (Type) <i>Sumio Uematsu</i> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/10/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Ritchie Hwy Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <i>J. J. Cowan + Son Inc. 23, Md.</i>		25D. ADDRESS <i>23, Md.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 2585				65 2585	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>DOROTHY DI MATTEI</u>			2. DATE AND HOUR OF DEATH <u>3/6/65</u> <u>1</u> <u>50</u> <u>A</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSP.</u>			4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <u>BALTIMORE</u> B. COUNTY <u>21-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>MARYLAND</u> D. STREET ADDRESS (If rural, give location) <u>914 PORRETT ST RYAN ST</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3-13-18</u>	9. AGE (In years last birthday) <u>46</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>	
13. FATHER'S NAME <u>John Phillips</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT ADDRESS <u>EMERGENCY room CHART - Hosp.</u>	
18. <u>241X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>LOBECTOMY FOR TB 1956</u>			CAUSE OF DEATH (A) <u>HYPOXIA</u> DUE TO (B) <u>ATHEIA + CHRONIC LONG DISEASE</u> DUE TO (C) <u>ATHEIA + CHRONIC LONG DISEASE</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>3/6/65</u> to <u>3/6/65</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>3/6/65</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>L. Bradley Baker</u>				23B. DATE SIGNED <u>3/6/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>LYNN BRADLEY BAKER</u>		23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-11-65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Balto National Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>John J. Cowan &amp; Sons</u>			
25D. ADDRESS <u>Balto, Md.</u>					

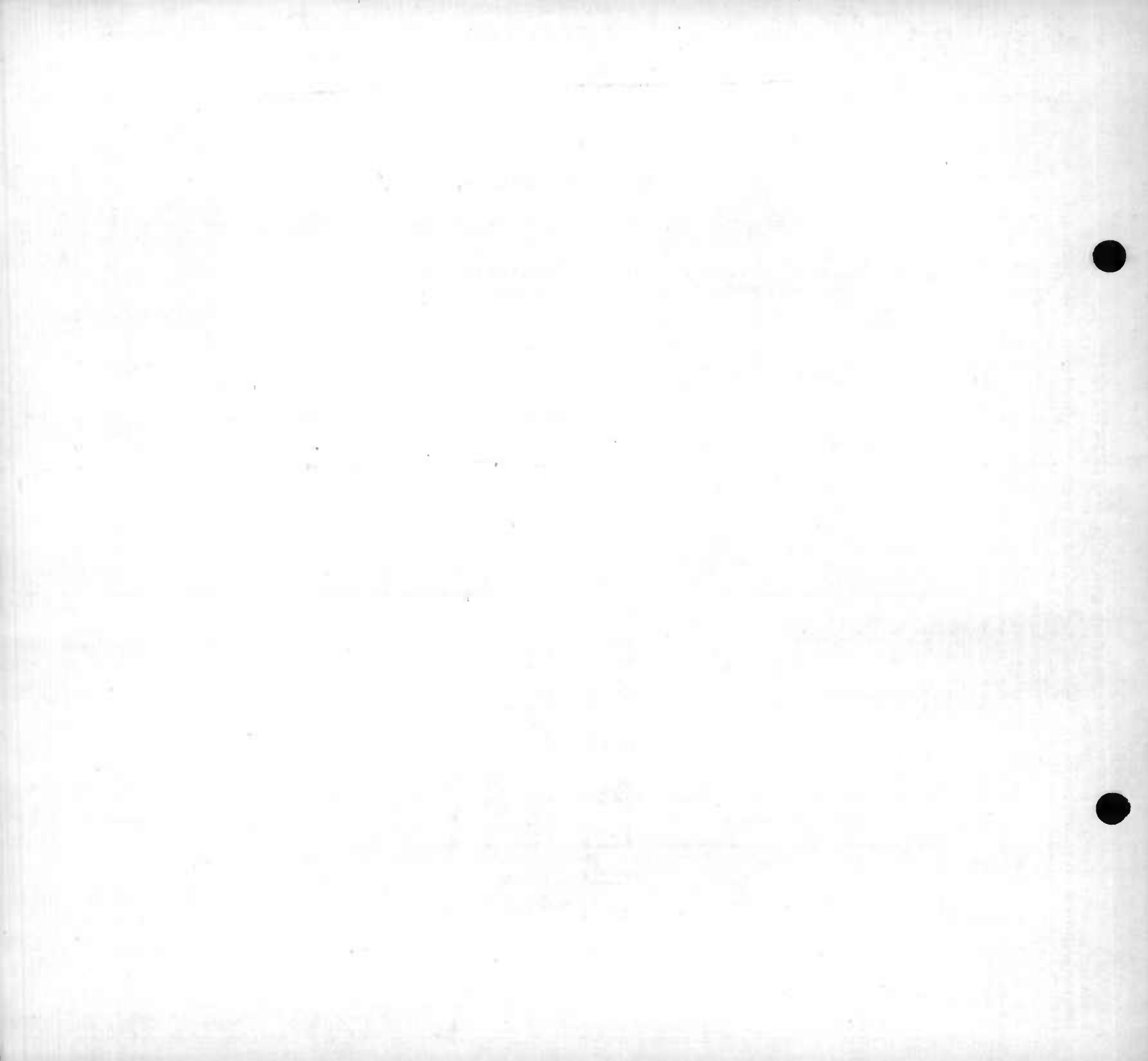


# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2586		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2586	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Baby Bey Macin		
2. DATE AND HOUR OF DEATH 3-3-65 18:40 P.M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY Balto		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00			D. STREET ADDRESS (If rural, give location) 16 Enchanted Hills Apt 101		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3-1-65	9. AGE (In years last birthday)	If Under 1 Yr. Months Days Hours Min. 2 6 32
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Charles Macin		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Mother		
ADDRESS Same			18. 776 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO Prematurity		
(B) DUE TO			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 3-1-1965 to 3-3-1965, that (I) (we) last saw the deceased alive on 3-3-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE E. C. CRUZ			23B. DATE SIGNED 3-3-65		
23C. PHYSICIAN'S NAME (Type) E. C. CRUZ			23D. ADDRESS Sinai Hospital		
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE March 5 1965		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Baltimore, Md		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 9 1965		25B. NAME OF REGISTRAR Robert E. Barker		25C. FUNERAL DIRECTOR Frank H. Newell	
25D. ADDRESS		25E. ADDRESS			





FUNERAL DIRECTOR: IMPORTANT

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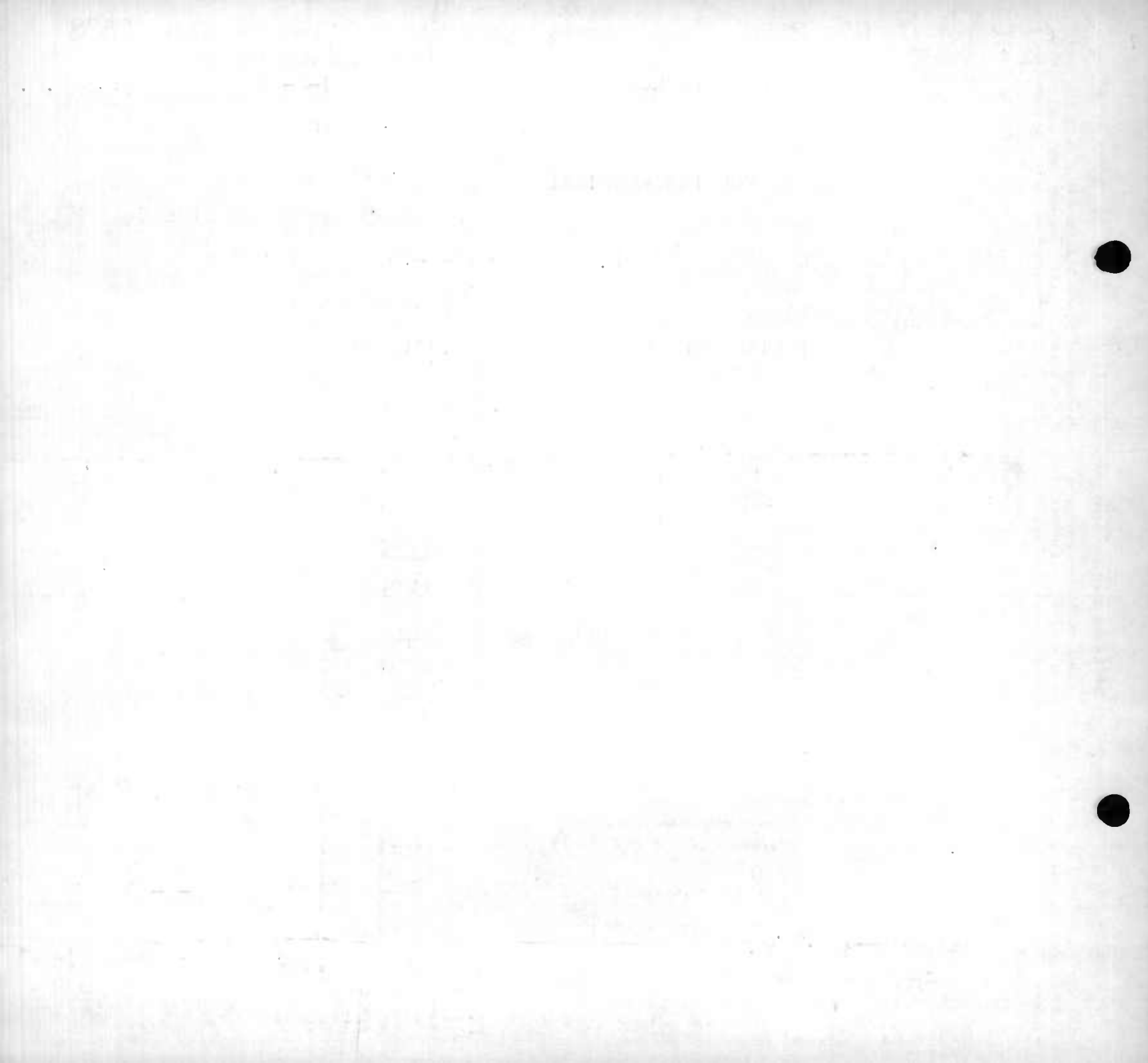
43-01-66 65-05185		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2587 4	
BIRTH NO. 65 2587		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Belser, Baby Girl, Catherine</b>		2. DATE AND HOUR OF DEATH <b>March 6, 1965 4:35 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		A. STATE <b>Maryland</b> B. COUNTY <b>13-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2412 Linden Avenue 21217</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>March 5, 1965</b>	9. AGE (In years last birthday)	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		14. MOTHER'S MAIDEN NAME
13. FATHER'S NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>RECORDS: BCH 4940 Eastern Avenue 21224</b>			
18. 773.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Distress Syndrome</b>		CAUSE OF DEATH (A) DUE TO <b>Respiratory Distress Syndrome</b> (B) <b>Prematurity</b> (C)		INTERVAL BETWEEN ONSET AND DEATH <b>13 55/60 Hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Acidosis</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Yes</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 5, 1965</b> to <b>March 6, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 6, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. Wayne Klein</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>March 6, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>S. Wayne Klein</b>		23D. ADDRESS M.D. <b>4940 Eastern Avenue 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremated</b>		24B. DATE <b>3/8/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore City Hospitals</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>2522</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2588		CERTIFICATE OF DEATH		Registered No. 65 2588	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
RUTH TAYLOR				3-6-65 12:35 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				MARYLAND		15-06			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				BALTIMORE					
				D. STREET ADDRESS (If rural, give location)					
				1724 ASHBURTON STREET					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
FEMALE		COLORED		MARRIED		11-6-03		61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Homemaker						Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
WILLIAM JOHNSON				HATTIE HILL					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			
NO				NONE		Chandler Taylor 1724 Ashburton St			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO					
ANTECEDENT CAUSES				(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)					
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
				BRONCHOPNEUMONIA					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 1964, 19 to MARCH 6, 1965, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED	
DR. ROBERT SCORGIE								3-6-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
				JHH					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		3/10/65		Mt. Auburn Cemetery		Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAR 9 1965		Robert E. Taylor		Earl Gilmore		1827 W. North Ave			



1  
0-540

65 2589

BALTIMORE CITY HEALTH DEPARTMENT

65 2589

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES ONEAL

2. DATE AND HOUR PRONOUNCED DEAD

March 5, 1965

1:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2221 Druid Hill Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

March 26, 1931

9. AGE (In years  
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Ford Mack

14. MOTHER'S MAIDEN NAME

Dorothy Oneal

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Dorothy Oneal 22 Cottage Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Convulsive disorder

cerebral cortical softenings

(B) DUE TO

(C) DUE TO

II  
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-6-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/10/65

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 9 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

George H. Filer 1348 N. Calhoun St

ADDRESS

WALLER HOBBS

PAC CONTENT

USA

John S. Brown



1  
L. 200

65 2590

BALTIMORE CITY HEALTH DEPARTMENT

65 2590

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DOREEN LEWIS

2. DATE AND HOUR PRONOUNCED DEAD

March 7, 1965 1:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1806 W. North Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Never Married

8. DATE OF BIRTH

Jan. 10, 1958

9. AGE (in years  
last birthday)

7

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Franklin J. Lewis

14. MOTHER'S MAIDEN NAME

Rosa Hines

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Rosa Lewis 1806 W. North Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple traumatic injuries  
DUE TO

(B) DUE TO

(C) DUE TO

II  
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?  
yes21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

North Ave. 46 ft. west of Fulton Ave.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
March 6, 1965 7:10 P.M.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

pedestrian struck by auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
March 7, 196523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/10/65

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 9 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

James H. Wilson 1348 N. Calhoun St.

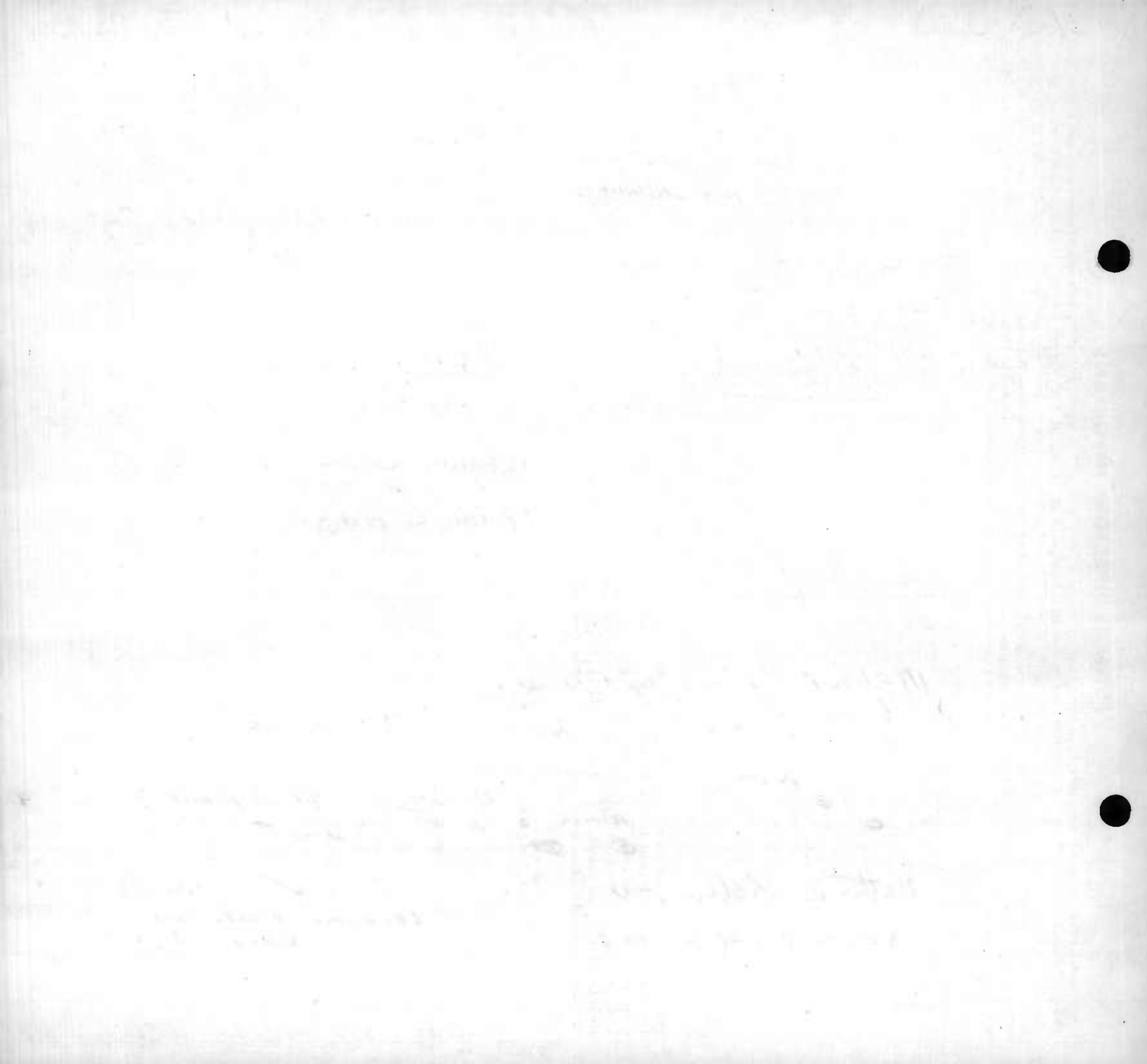
ADDRESS

VALLEY PORT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

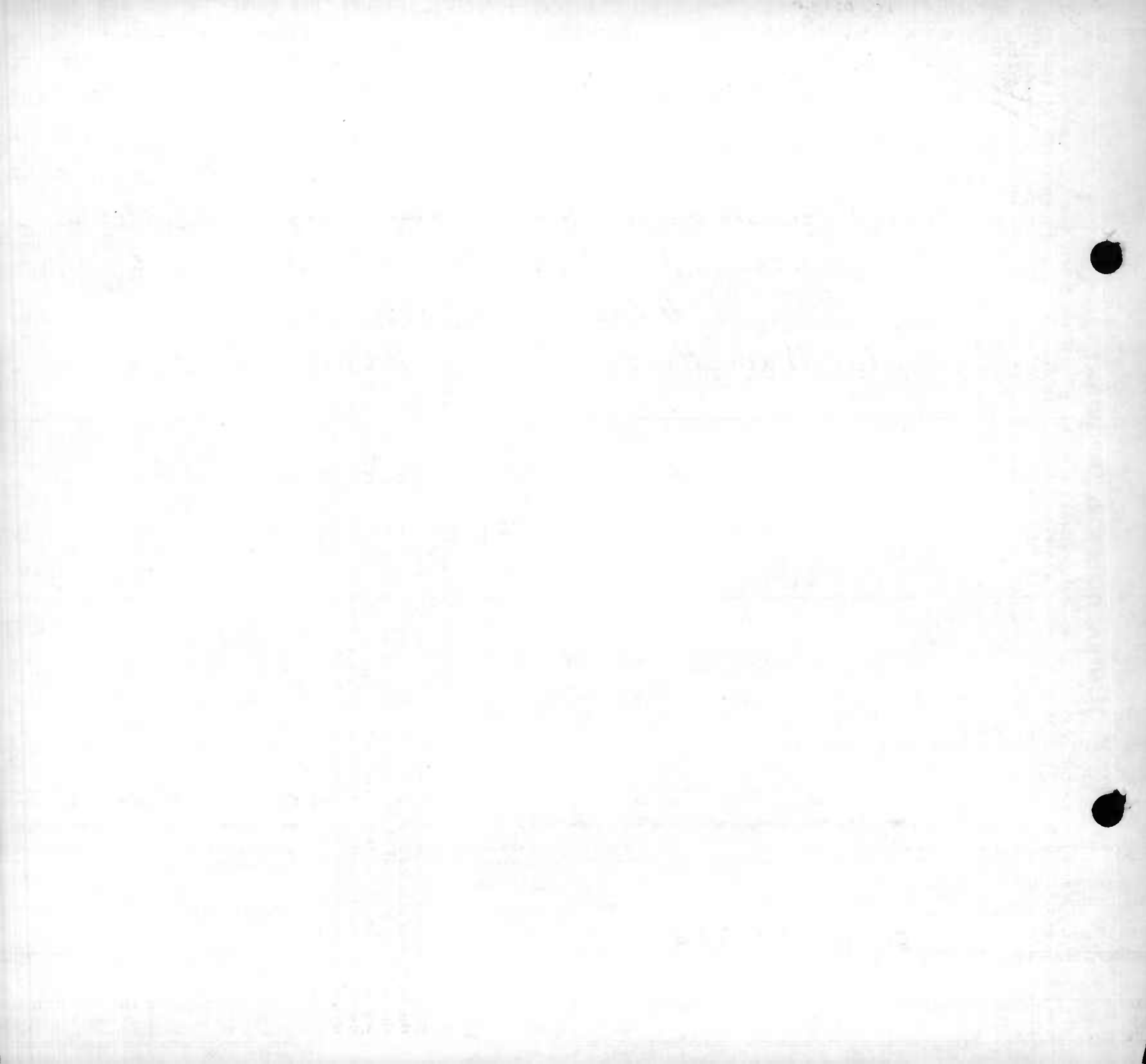
BIRTH NO. <b>65 2591</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 2591</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>LENA PLEET</b>			2. DATE AND HOUR OF DEATH <b>MARCH 6, 1965 7 PM</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LEVINDALE HEBREW HOME AND INFIRMARY</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-17</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b> D. STREET ADDRESS (If rural, give location) <b>GREENSPRING + BELVEDERE AVE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLOAK BUS.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S 9</b>			13. FATHER'S NAME <b>WILLIAM</b>		
14. MOTHER'S MAIDEN NAME <b>BALLA</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>216-32-8444</b>			17. INFORMANT ADDRESS <b>HARRY BLUM - 4021 FALLSTAFF TRD</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>159 X1</b>			CAUSE OF DEATH (A) <b>Metastatic Carcinoma to Lungs</b> DUE TO <b>Liver and Bones</b> (B) <b>? Probable GI Malignancy</b> DUE TO (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH <b>App 8 months</b> <b>8 months</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>None</b>					
19A. DATE OF OPERATION <b>10/5/1964</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Repair pathologic study Fracture left hip - adenocarcinoma</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b>	
21D. TIME OF INJURY (APPROX.) <b>None</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>None</b>	
22. I certify that (this hospital) attended the deceased from <b>11/24</b> 19 <b>64</b> to <b>MARCH 6</b> 19 <b>65</b> , that I (we) last saw the deceased alive on <b>MARCH 6</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date <b>at 7 PM</b> and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Nathan B. Rabhan, M.D.</b>				23B. DATE SIGNED <b>March 6, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>NATHAN B. RABHAN, M.D.</b>				23D. ADDRESS <b>LEVINDALE HEBREW HOME &amp; INFIRMARY BALTO 15, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/7/1965</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HERRING RUN</b>	
24D. LOCATION <b>BALTO. MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Stanley, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Sylvan S. Lewis &amp; Son - 3319 OLIVIER AVE</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

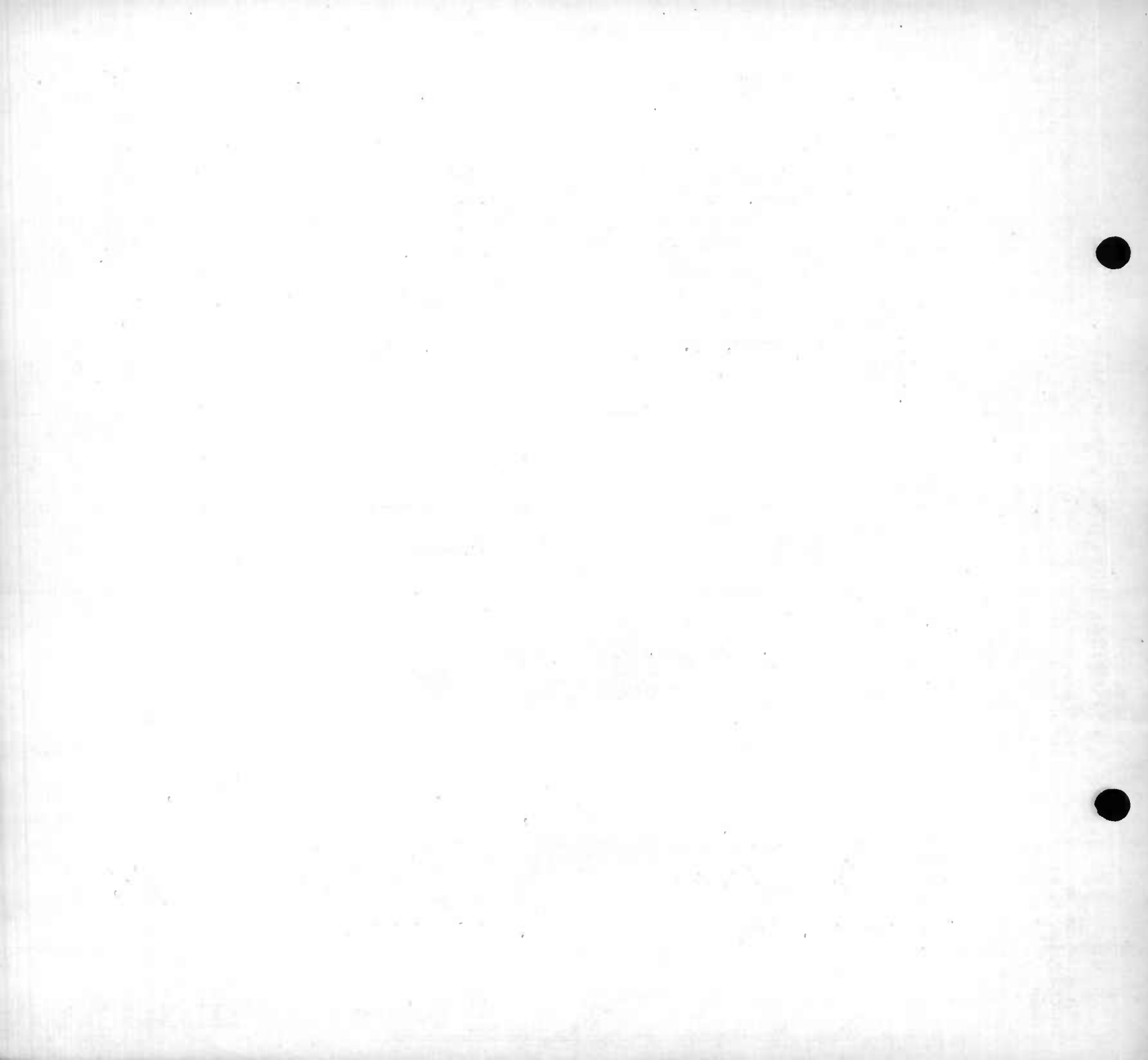
BIRTH NO. <b>65 2592</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2592</b>	
<b>CERTIFICATE OF DEATH</b>					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<b>Baby Girl Hare.</b>		<b>Feb. 25, 1965 9:00 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
<b>South Baltimore General Hosp.</b>			<b>Maryland AA</b>		
5. SEX			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
<b>F.</b>			<b>Baltimore #212255240</b>		
6. RACE			D. STREET ADDRESS (If rural, give location)		
<b>White</b>			<b>4024 BELLE GROVE RD.</b>		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH		
<b>Never Married</b>			<b>2-20-65</b>		
9. AGE (In years last birthday)			10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
<b>N.B.</b>			<b>None</b>		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
<b>Balto, Md.</b>					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<b>William Hare.</b>			<b>Denise Hodges.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
<b>776X I</b>			<b>Prematurity</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO		
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
			<b>5 days</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<b>2</b>				<b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>2-20 1965</b> to <b>2-25 1965</b> , that <del>we</del> (we) last saw the deceased alive on <b>2-25 1965</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<b>E. V. McGinley</b>				<b>2-25-65</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
<b>Edgar V. McGinley</b>				<b>55 GH</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<b>JAN 8 1965</b>		<b>8 1965</b>		<b>ANATOMY BOARD OF MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>MAR 9 1965</b>		<b>Edgar V. McGinley</b>		<b>2 MORTUARY SERVICE - BCHD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-00715 65 2593		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 2593	
1. NAME OF DECEASED (Type or Print) Baby of Sandra Spence				2. DATE AND HOUR OF DEATH March 2, 1965 6:35 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-10 D. STREET ADDRESS (If rural, give location) 3818 1/2 Belle Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH March 1, 1965	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dennis Edward Murphy, Jr.				14. MOTHER'S MAIDEN NAME Sandra Spence			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 759.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Pulmonary hemorrhage DUE TO Congenital absence of the abdominal muscles (B) DUE TO Hydronephrosis (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 1, 1965 to March 2, 1965, that (I) (we) last saw the deceased alive on March 2, 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Vincent R. Blake				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED March 3, 1965	
23C. PHYSICIAN'S NAME (Type) Vincent R. Blake				23D. ADDRESS M.D. 1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE JAN 8 1965		24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 9 1965		25B. NAME OF REGISTRAR P. E. E. E. E.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	

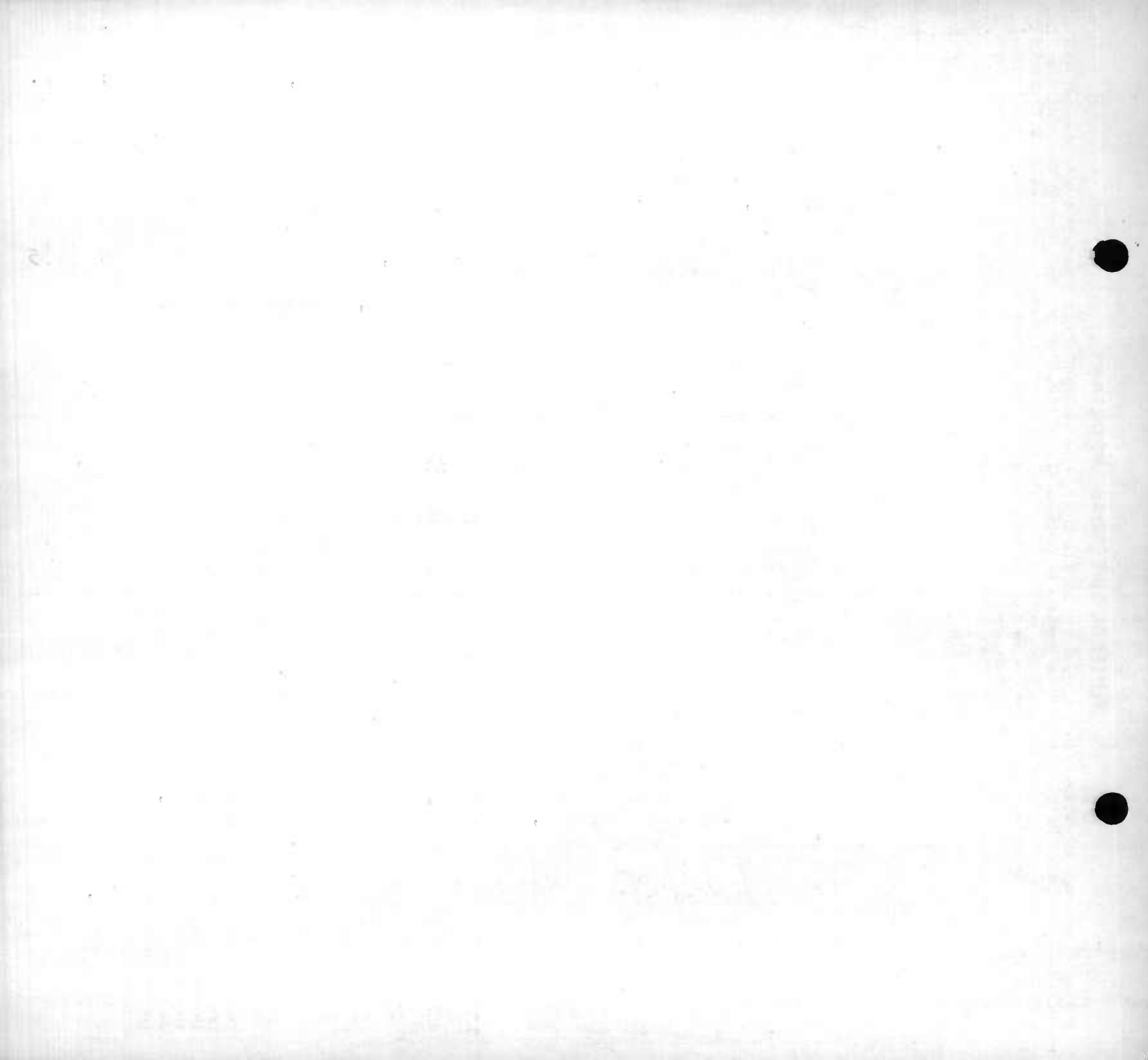




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

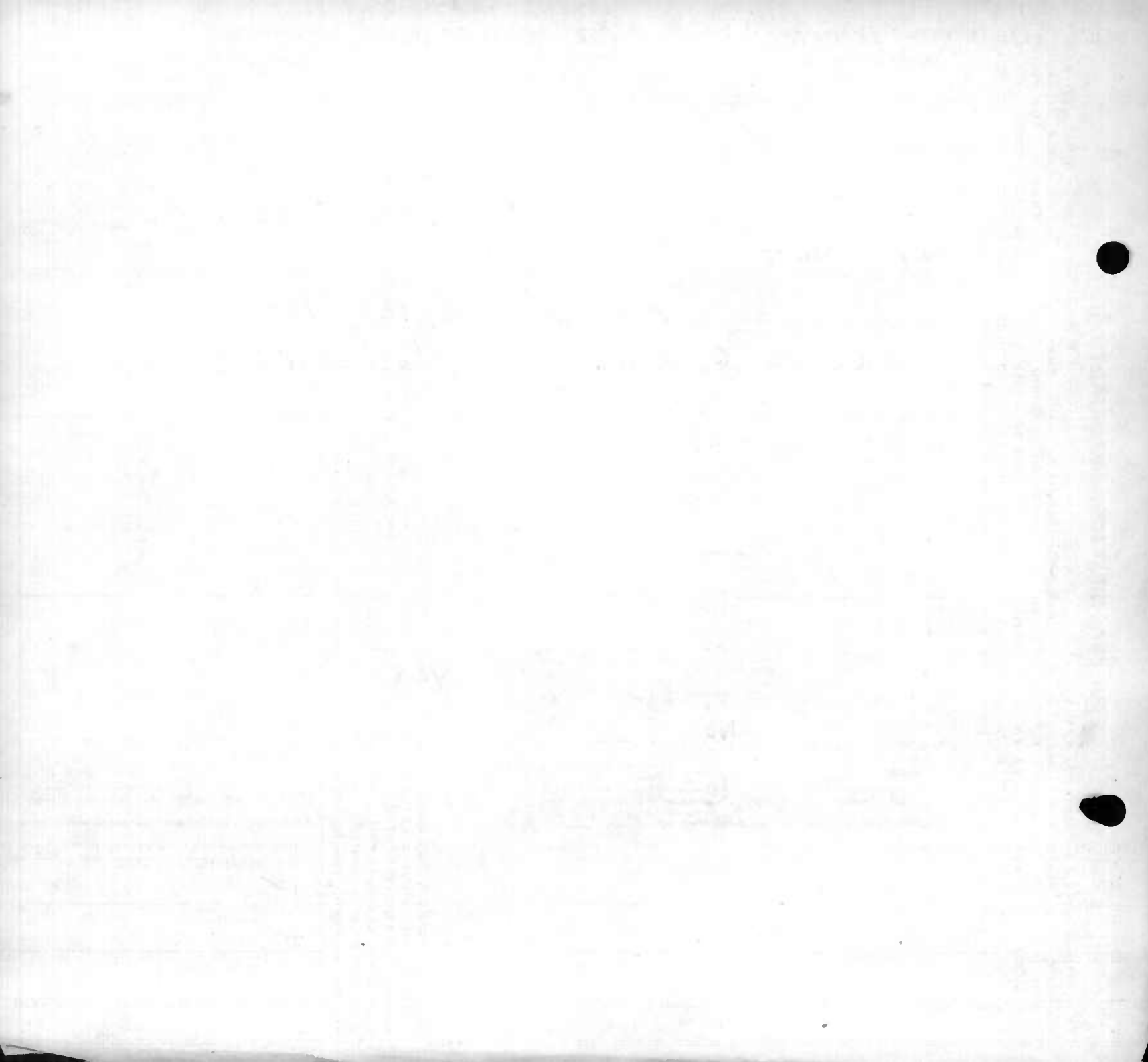
BIRTH NO. <b>65 2594</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2594</b>	
M.E. CASE NO.		CERTIFICATE OF DEATH		1	
1. NAME OF DECEASED (Type or Print) <b>GIRL</b> <b>Baby of Shirley Bishop</b>			2. DATE AND HOUR OF DEATH <b>March 2, 1965</b>   <b>12:40 a.m.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital</b> <b>1514 Division Street</b> <b>Baltimore, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1642 Thomas Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>March 1, 1965</b>	9. AGE (In years last birthday) <b>4</b>	If Under 1 Yr. Months: <b>4</b> Days: <b>35</b> If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Charles Taylor</b>			14. MOTHER'S MAIDEN NAME <b>Shirley Bishop</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH <b>762.51</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 1, 1965</b> to <b>March 2, 1965</b> and that (I) (we) last saw the deceased alive on <b>March 2, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Vincent R. Blake</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>March 4, 1965</b>
23C. PHYSICIAN'S NAME (Type) <b>Vincent Blake</b>			23D. ADDRESS M.D. <b>1514 Division Street</b>		
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <b>JAN 8 1965</b>		24C. NAME OF CEMETERY OR CREMATORY <b>UNIVERSITY CITY MEDICINE MORTUARY SERVICE - BCHO</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 9 1965</b>		25B. NAME OF REGISTRAR <b>R. E. E. E. E. E.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTUARY SERVICE - BCHO</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2595 4	
BIRTH NO. 65 04601		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Bay Burt		2. DATE AND HOUR OF DEATH 2/28/65 1:41 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland 24-01			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #			
D. STREET ADDRESS (If rural, give location)		South Baltimore General Hosp. 1304 Towson. St.			
5. SEX Bay	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) S.	8. DATE OF BIRTH 2-27-65	9. AGE (In years last birthday) 11.B.	10. Under 1 Yr. Months Days 1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY None.		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Edward G. Burt		14. MOTHER'S MAIDEN NAME Catherine Braun	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Respiratory distress syndrome (B) Cerebral Anoxia (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-27-1965 to 2-28-1965, that (I) (we) lost saw the deceased olive on 2-28-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Badie		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 2-28-65	
23C. PHYSICIAN'S NAME (Type) Dr. Dawood Badie		23D. ADDRESS South Balto. General Hospital			
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) JAN 8 1965		24C. NAME OF CEMETERY OR CREMATORY MARYLAND ANATOMY BOARD		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 9 1965		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHO	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>65 2596</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 2596</u>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>BARNHART, GENEVIEVE M.</u>				2. DATE AND HOUR OF DEATH <u>3/7/65</u> <u>1 40 A</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>MARYLAND GENERAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Pennsylvania</u> B. COUNTY <u>Maryland</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MARYLAND GENERAL</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>26-81</u>			
				D. STREET ADDRESS (If rural, give location) <u>6008 Mannington Ave</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED (specify)) <u>WIDOWED</u>		8. DATE OF BIRTH <u>10-9-05</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALONZO STEELE</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Slicer</u>			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>daughter</u>	
				ADDRESS <u>Same</u>			
18. <u>200.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>lympho sarcoma</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>3/7/65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NO</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/3/65</u> to <u>3/7/65</u> that (I) (we) lost saw the deceased alive on <u>140 AM 3/7/65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jooh Hyun Sohn</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/7</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jooh Hyun Sohn</u> M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-11-1965</u>		24C. NAME of CEMETERY or CREMATORY <u>St. John's Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Camp Hill Penna</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 10 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>LaSalle Funeral Home</u> ADDRESS <u>7401 Belair Rd</u>			

George Washington



W F

George Washington

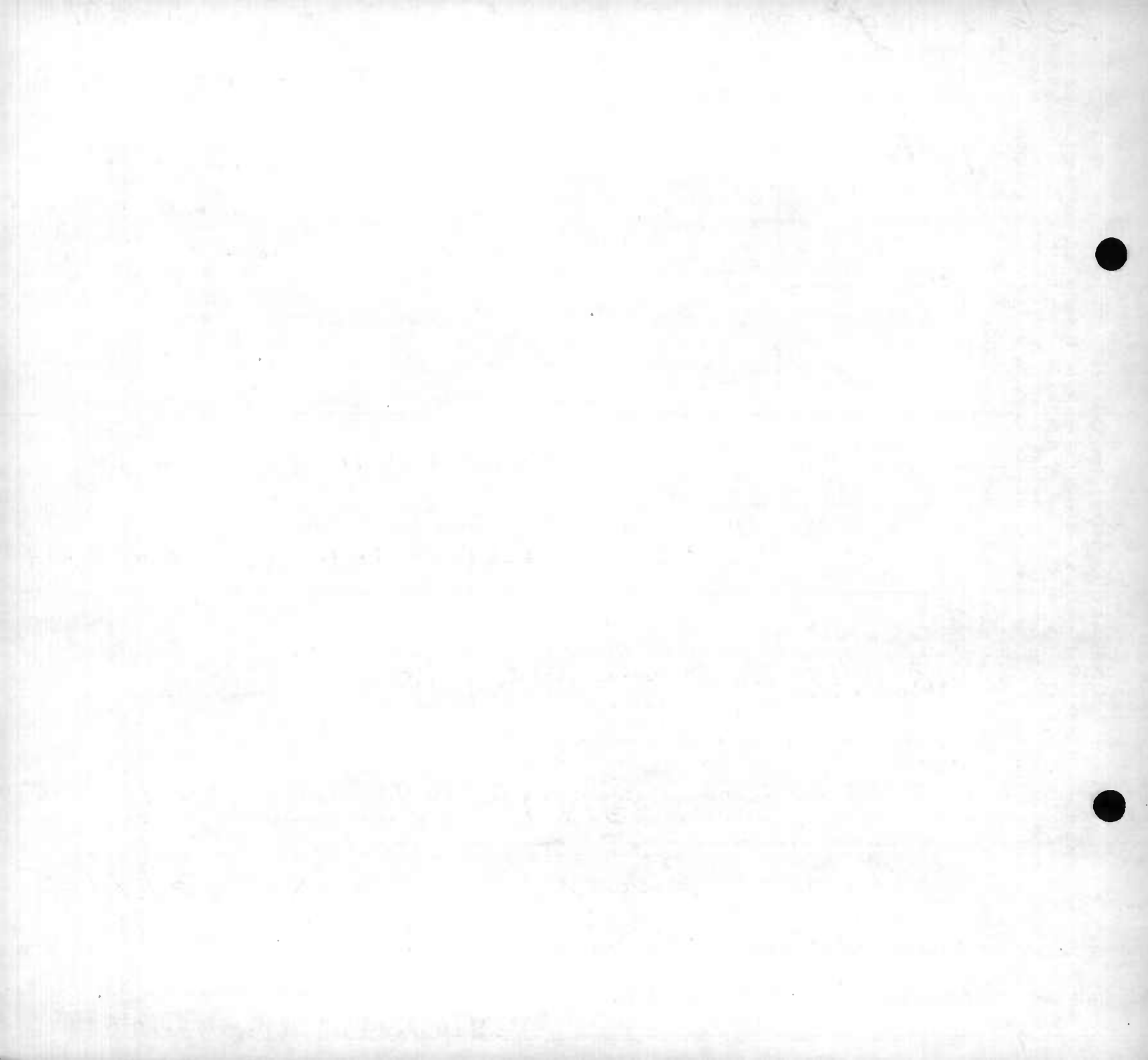
George Washington  
1789-1799  
President  
of the United States

George Washington  
1789-1799  
President  
of the United States

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2597	
BIRTH NO. 65 2597		CERTIFICATE OF DEATH		Registered No. 65 2597	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Parthree Edwin Allen.		2. DATE AND HOUR OF DEATH 3/7/65 5.05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Md. 5300	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hospital for The Women of Md. Lafayette Ave - + John sts.		D. STREET ADDRESS (If rural, give location) 5828 Westwood Avenue - Balt. 6			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 10-12-04	9. AGE (In years lost birthday) 60 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10B. KIND OF BUSINESS OR INDUSTRY York Penna.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Parthree John Greer		14. MOTHER'S MAIDEN NAME Rappold Mary M.	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-2067		17. INFORMANT Mrs Ruby A. Parthree 5828 Westwood Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CORONARY OCCLUSION		INTERVAL BETWEEN ONSET AND DEATH 5 MIN			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. BLEEDING PEPTIC ULCER ONE MONTH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 12/28/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BLEEDING PEPTIC ULCER		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/20/1965 to 3/7/1965, that (I) (we) lost saw the deceased alive on 3/7/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jacques E. Rioux M.D.		23B. DATE SIGNED 3/7/65		23C. PHYSICIAN'S NAME (Type) JACQUES E. RIOUX MD M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-11-1965		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Co Md		25A. DATE REC'D BY HEALTH DEPT. MAR 10 1965		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Lafayette Funeral Home 7401 Belair Road		25D. ADDRESS 36			

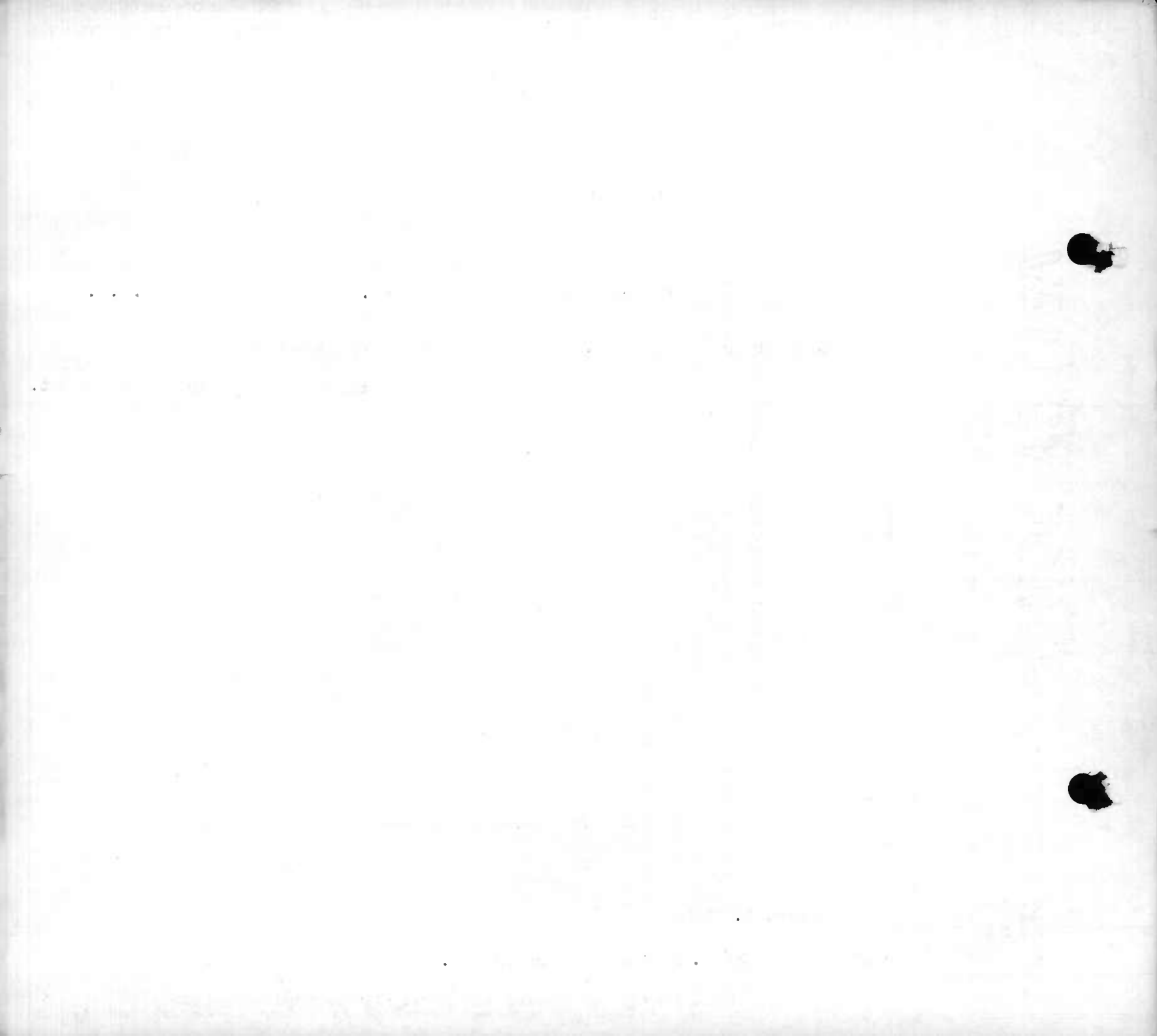




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2598		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2598	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Mary Bayer		2. DATE AND HOUR OF DEATH 3-9-65 12:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY 10-01	
Mercy Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1200 Valley St			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S.	8. DATE OF BIRTH 8-29-71	9. AGE (In years last birthday) 93	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Frank Bayer		14. MOTHER'S MAIDEN NAME Mary Ackieman		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Little Sisters of the Poor	
18. 433.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Congestive Heart Failure DUE TO (B) Atrial Fibrillation DUE TO (C) A.S.C.U.N.D.		INTERVAL BETWEEN ONSET AND DEATH Years 2 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II Dehydration - Electrolyte Imbalance Sepsis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 12-16-64 to 3-9-65, that (we) last saw the deceased alive on 3-9-65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert L. Dgle		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-9-65	
23C. PHYSICIAN'S NAME (Type) Robert L. Dgle		M.D. Hospital		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/12/65		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR MAR 10 1965		25C. FUNERAL DIRECTOR Philip Horvath Sins Orleans St	
				ADDRESS 2024	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2599		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2599	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARY REGINA HARDY		2. DATE AND HOUR OF DEATH March 7, 1965 5:30 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 28 S. Pulaski St.		A. STATE MARYLAND B. COUNTY 2004 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 28 S. Pulaski St.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH Feb. 3, 1877	9. AGE (In years lost birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRESSMAKER		10B. KIND OF BUSINESS OR INDUSTRY DRESSMAKING		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Joseph Bosley		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 144-01-7139		17. INFORMANT ADDRESS Dorothy Druggie 28 S. Pulaski St.	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH IA) Arteriosclerotic Heart Disease DUE TO IB) age DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? If in Baltimore City, give exact location	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 1, 1965 to March 15, 1965, that (I) (we) last saw the deceased alive on March 15, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Morris B. Schreiber M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 3-9-65	
23C. PHYSICIAN'S NAME (Type) MORRIS B. SCHREIBER		23D. ADDRESS M.D. 151 W. Lombard St. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-11-65		24C. NAME OF CEMETERY or CREMATORY Loudon PARK	
24D. LOCATION BALTIMORE, Md					
25A. DATE REC'D BY HEALTH DEPT. MAR 10 1965		25B. NAME OF REGISTRAR R. E. E. E.		25C. FUNERAL DIRECTOR GEO. L. SCHWABER 2101 Frederick Ave	



B-655

## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 2600		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2600	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) John Brennan		2. DATE AND HOUR PRONOUNCED DEAD March 6, 1965 10:25 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) City Hospitals		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Glen Burnie D. STREET ADDRESS (If rural, give location) 7841 Baltimore Annapolis Blvd. 62-00	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH July 21, 1946
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junior Salesman		10B. KIND OF BUSINESS OR INDUSTRY Coco-Cola Co.	11. BIRTHPLACE (State or foreign country) Philadelphia Pa.
13. FATHER'S NAME Robert E. Brennan, Sr.		14. MOTHER'S MAIDEN NAME Phyllis Kobylinski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Navy Reserve		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Mr. Robert E. Brennan, Sr. (father) Same As #2
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 48 IX DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Gunshot wound of chest DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION March 6, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. March 6, 1965 10:05P		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2700 blk. Broening Highway		21D. TIME OF INJURY (APPROX.) March 6, 1965 10:05P	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? shot during altercation	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John E. Adams, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED March 7, 1965			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE March 10, 1965	
23C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Pk.		23D. LOCATION (City, town, or county) (State) Glen Burnie, Md. V	
24A. DATE REC'D BY HEALTH DEPT. MAR 10 1965		24B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24C. FUNERAL DIRECTOR R. K. Singleton		24D. ADDRESS Glen Burnie, Md.	

July 21, 1942

Sample

Trans. Robinson Co. - Col. Co.

Robert E. Robinson, Jr.

Philip Koploski

Antenna for Robert E. Robinson, Jr.

General Manager Glen H. Robinson, Jr.

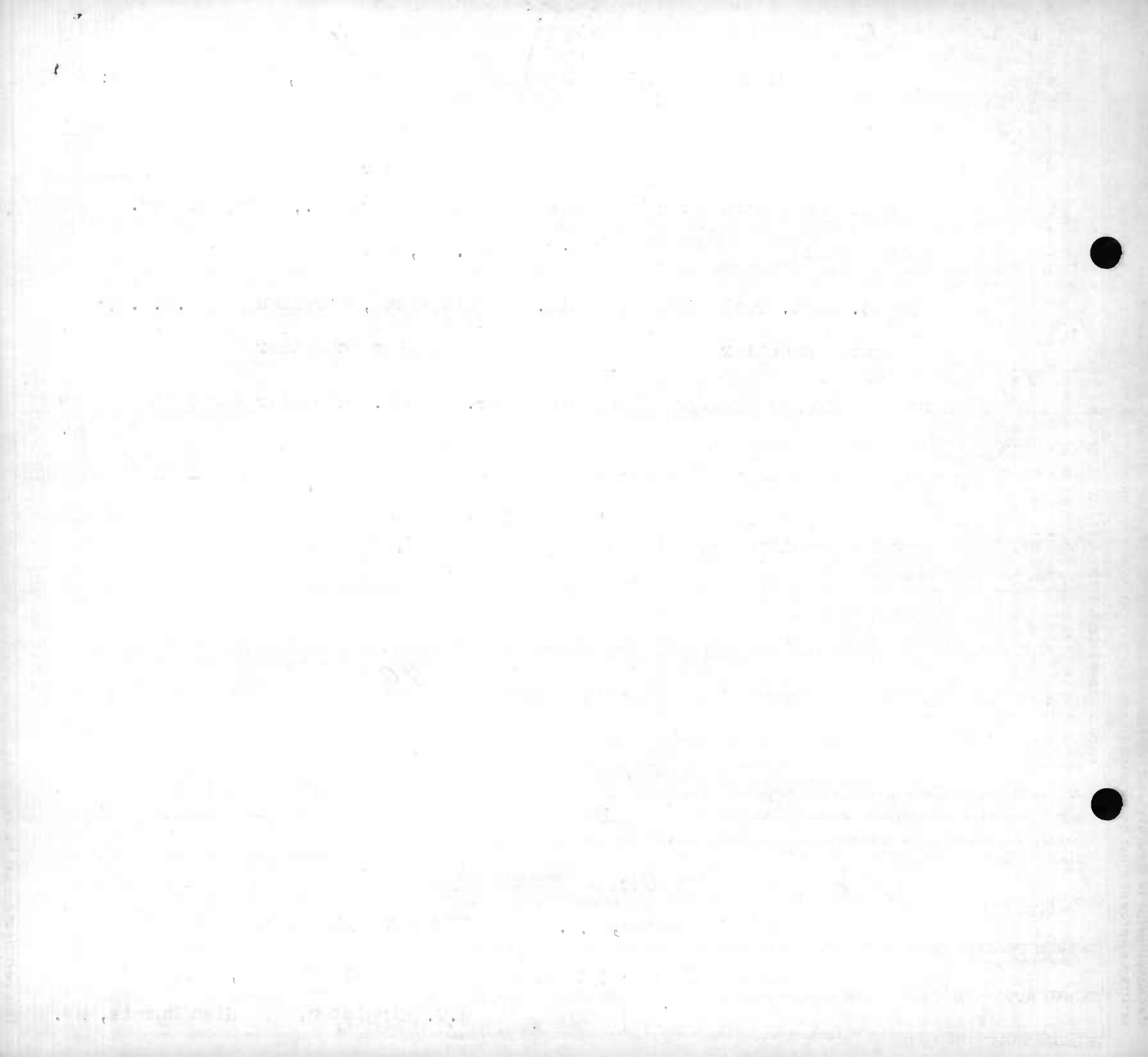
R. Koploski - Glen H. Robinson, Jr.

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2601</u>	
BIRTH NO. <u>65 2601</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAM HENRY SCHUEHLER</b>		2. DATE AND HOUR OF DEATH <b>March 3, 1965 9:20 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Hanover</b>			
		D. STREET ADDRESS (If rural, give location) <b>Camp Meade Rd., &amp; Poplar Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 23, 1887</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Const. Supt. (ret)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>City of Balto.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Schuehler</b>		14. MOTHER'S MAIDEN NAME <b>Louise Schwitzer</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT ADDRESS <b>Mr. John P. Schuehler (son) Same As #4</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Myocardial Infarction</b> DUE TO (B) <b>Atherosclerotic Heart Disease</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>06/2</b> 19 <b>57</b> to <b>3/3</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>2/11</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Benjamin Berdamm</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>2/5/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Benjamin Berdamm, M.D.</b>		23D. ADDRESS <b>7809 Liberty Rd</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>March 6/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>R.V. Singleton, Glen Burnie, Md.</b>	



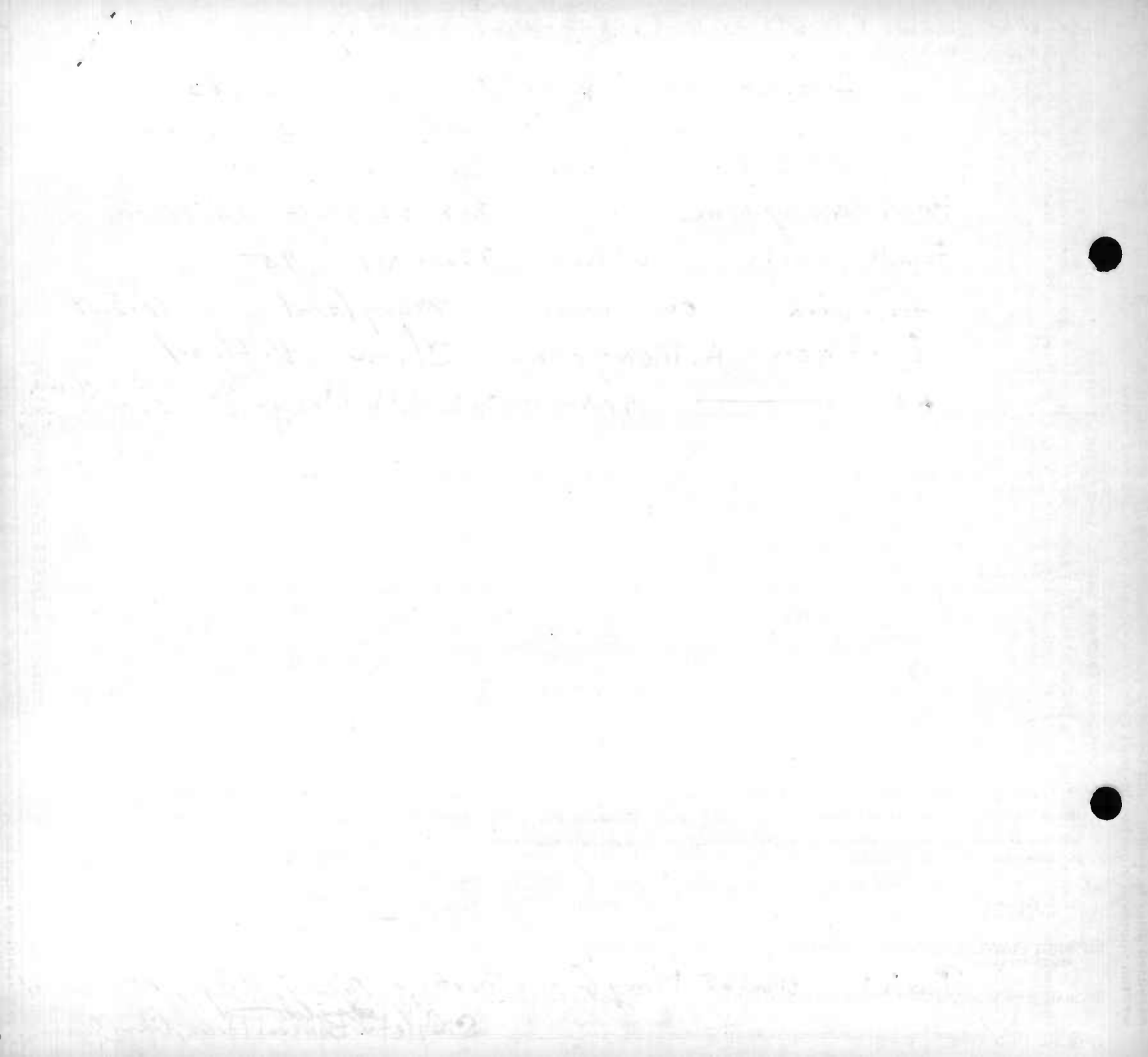




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2602		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2602	
M.E. CASE NO.		CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) <b>Laura Louise Clay</b>	
2. DATE AND HOUR OF DEATH <b>4 March 1965</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>Balto. Co.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>5313 Edmunson Ave</b> <b>Hood Nursing Home</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 20 5300</b>		D. STREET ADDRESS (If rural, give location) <b>Box-53-Rt. 16- Middle River Rd</b>	
5. SEX <b>Female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>9 June 1889</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State of foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Luther A. Montgomery</b>		14. MOTHER'S MAIDEN NAME <b>Clara V. Hood</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Ms. Ruth Gray - Glen Burnie Rd</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>422.1 I</b>		CAUSE OF DEATH (A) <b>A.S.C. V.A. -</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Congestive Heart Failure 1 week</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-2-1964</b> to <b>3-4-65</b> 19 <b>65</b> that (I) (we) last saw the deceased alive on <b>3-4-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James S. Howell</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3-6-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>James S. Howell</b>		23D. ADDRESS <b>Catonville</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8 March 65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Piney Grove Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Mount Airy, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 10 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>2015 K. Taylor</b>			
25D. ADDRESS <b>2015 K. Taylor</b>		25E. ADDRESS <b>2015 K. Taylor</b>			



M 620

65 2603

BALTIMORE CITY HEALTH DEPARTMENT

65 2603

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT F. MYERS

2. DATE AND HOUR PRONOUNCED DEAD

3-7-65

4:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE CORRECTED D 3-22-65

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

BALTIMORE CITY HOSPITAL - DOA

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Essex

D. STREET ADDRESS (If rural, give location)

340 Sassafras Road 21221

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 27, 1939

9. AGE (In years  
last birthday)

26

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Stockroom Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Trucking Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Fredrick Myers

14. MOTHER'S MAIDEN NAME

Edna Bryant

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

1962

16. SOCIAL  
SECURITY NO.

216-36-2311

17. INFORMANT

Edna Carrigan Same

ADDRESS

18. E 823.4

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Depressed skull fracture  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Road

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Backriver Neck Road

120 ft. South of Bay Avenue

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year)  
3 7 '65

(Hour)  
4:14 PM

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?  
Driver of auto which  
left road and struck a tree

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

3-8-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/11/65

23C. NAME of CEMETERY or CREMATORY

Sacred Heart of Jesus

23D. LOCATION

Baltimore Co., Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 10 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Bruzdzinski Funeral Home 1407 Eastern Ave. #2

Letter from M.E.'s office

3-22-65 M.H.

VALLEY FORD

Miss Val

W. 630

65 2604		BALTIMORE CITY HEALTH DEPARTMENT		65 2604	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		THOMAS WARD (Thomas M. Ward)		2. DATE AND HOUR PRONOUNCED DEAD March 5, 1965 6:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS		B. COUNTY Balt		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	
8. DATE OF BIRTH October 14, 1894		9. AGE (In years lost birthday) 70		10. BIRTHPLACE (State or foreign country) McKeesport, Pennsylvania	
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. FATHER'S NAME ? WARD		13. MOTHER'S MAIDEN NAME ANNA O'TOOLE	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. I		15. SOCIAL SECURITY NO. 167-01-5671		16. INFORMANT Mr. George Bosche	
17. ADDRESS 7736 Old North Point Rd.		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. DATE OF OPERATION 0		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		25. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
26. TIME OF INJURY (APPROX.)		27. INJURY OCCURRED		28. HOW DID INJURY OCCUR?	
29. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		30. ACTUAL SIGNATURE John E. Adams, M.D.		31. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
32. DATE REC'D BY HEALTH DEPT. MAR 10 1965		33. NAME OF REGISTRAR Robert E. Taylor, M.D.		34. FUNERAL DIRECTOR 6224 Eastern Avenue Baltimore, Md. 21224	

VALLEY FORGE

1. 2.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2605				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2605	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>IRENE HENRY</b>				2. DATE AND HOUR OF DEATH <b>3-6-65 12:20 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>10-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1047 AISQUITH ST.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>12-10-05</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SOFT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Textile mill</b>		11. BIRTHPLACE (State or foreign country) <b>Va</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>PETER HENRY</b>			14. MOTHER'S MAIDEN NAME <b>JANE HERBERT</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-05-9193</b>		17. INFORMANT <b>Dorothy MacHenry 1047 Aisquith St</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>422.1x171x</b>				CAUSE OF DEATH (A) <b>Pulmonary Edema</b> DUE TO (B) <b>ASCVD + Congestive Heart Failure</b> DUE TO (C) <b>Amnesia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b> <b>3 wks.</b> <b>2 days.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>H/o Ca of Cervix - 13 yrs. cure</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>No</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in, or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPRX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/3</b> 19 <b>65</b> to <b>3/6</b> 19 <b>65</b> and that (I) (we) last saw the deceased alive on <b>3/6</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Richard L. Popp</b>				23B. DATE SIGNED <b>3-8-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>RICHARD L POPP</b>		23D. ADDRESS <b>2610</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>3-11-65</b>	24C. NAME OF CEMETERY or CREMATORY <b>MT. CARMARY</b>		24D. LOCATION (City, town, or county) (State) <b>D.A. COUNTY, MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 10 1965</b>		25B. NAME OF REGISTRAR <b>Chas. S. ...</b>		25C. FUNERAL DIRECTOR <b>Joseph B. ...</b>			

YOUNG - 1911

TO THE HONORABLE SECRETARY OF THE  
NAVY  
WASHINGTON, D. C.

DEAR SIR:

I have the honor to acknowledge  
the receipt of your letter of the  
10th inst.

Yours very truly,  
Richard M. [Signature]  
3/22  
X

12. M. [Signature]



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2606</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2606</b>	
M.E. CASE NO.		1. NAME OF DECEASED <b>WILEY, MRS. MARGARET A</b>		2. DATE AND HOUR OF DEATH <b>3/7/65 4 20 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2709</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balt. more</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL</b>		D. STREET ADDRESS (If rural, give location) <b>1636 Northbourne Rd. #12</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>11/8/89</b>	9. AGE (in years lost birthday) <b>25</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wisconsin Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Ralph M Connable dec</b>		14. MOTHER'S MAIDEN NAME <b>CLARA Shoup dec</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>husband</b> ADDRESS <b>same</b>	
18. <b>42011</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>myocardial infarction</b>		CAUSE OF DEATH (A) DUE TO <b>myocardial infarction</b> (B) DUE TO <b>Arteriosclerotic cardiovascular disease</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>3/6 19 65</b> to <b>3/7 19 65</b> , that (1) (we) last saw the deceased alive on <b>4 20 AM 3/7 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jooh Hyun Sohn</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/7</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jooh Hyun Sohn</b>		23D. ADDRESS <b>Maryland General Hosp.</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-10-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>DRUID RIDGE</b>	
24D. LOCATION (City, town, or county) (State) <b>PIKESVILLE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>JOHN O. MATCHELL &amp; SONS, INC. 1900 EUTAW PL.</b>	

Handwritten text at the top right, possibly a date or reference number.



Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

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Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.



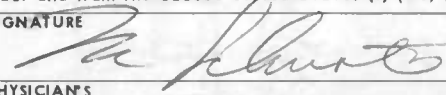
Handwritten text at the bottom right, possibly a date or reference number.

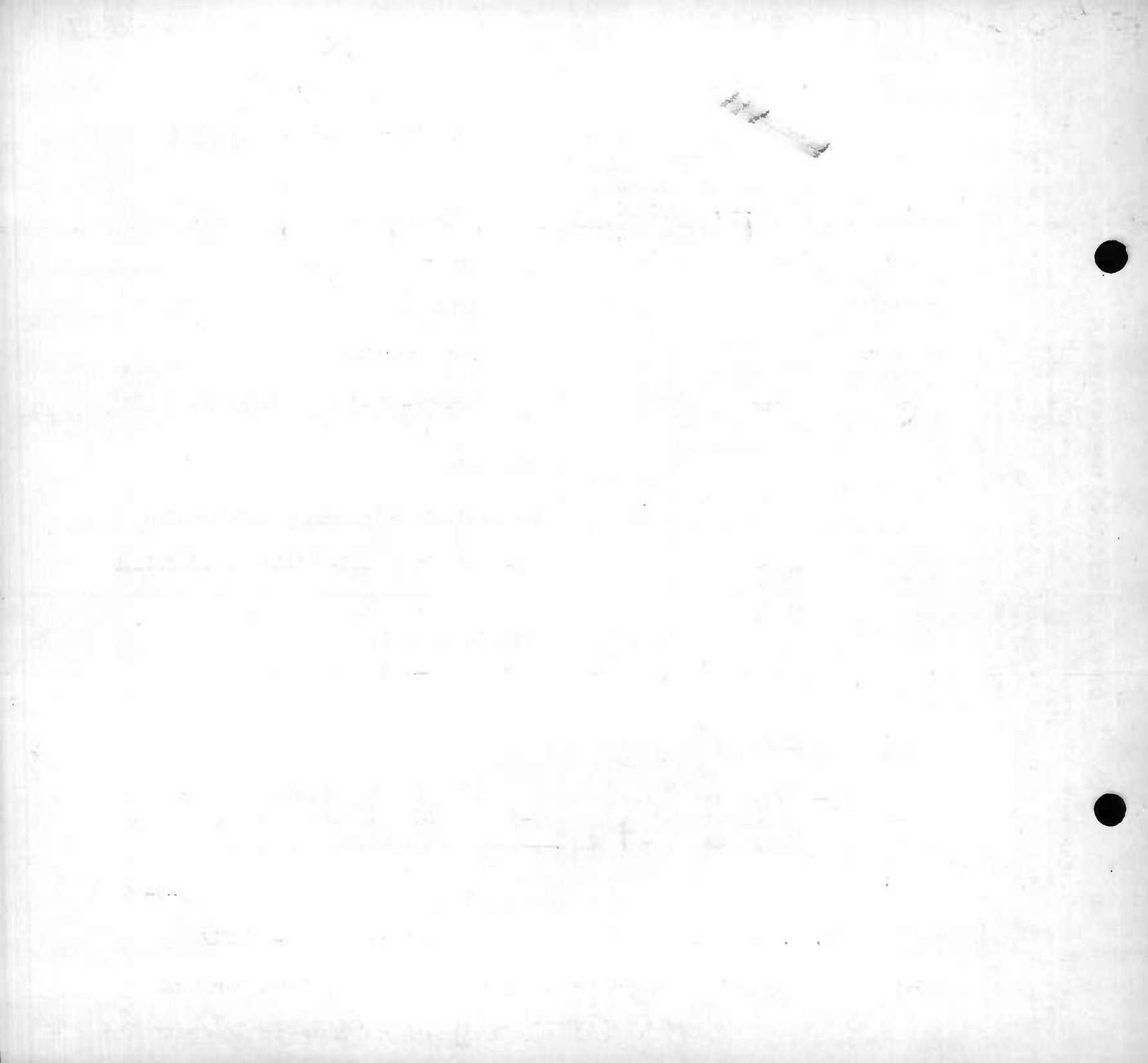
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Handwritten text, possibly a name or title.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2607				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2607	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Evelyn M. Bradshaw				2. DATE AND HOUR OF DEATH March 5, 1965 3 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland - Somerset B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Crisfield 69-00 D. STREET ADDRESS (If rural, give location) Mariners Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11-10-14	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		10B. KIND OF BUSINESS OR INDUSTRY Beauty Shop		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lee Mears				14. MOTHER'S MAIDEN NAME Cora Sterling			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Records-BCH-4940 Eastern Ave #21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (A) Pneumonia DUE TO (B) Tuberculosis & Pulmonary Infiltration DUE TO (C) Tuberculosis & Peritonitis Renal Failure							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Myeloid Leukemia							
19A. DATE OF OPERATION 002-141-204-1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 12-8 1964 to 3-5 1965, that (H) (we) last saw the deceased alive on 3-5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  Dr. M. Schuster				23B. DATE SIGNED 3-5-65			
23C. PHYSICIAN'S NAME (Type) Dr. M. Schuster				23D. ADDRESS 4940 Eastern Avenue - #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/8/65		24C. NAME OF CEMETERY or CREMATORY Sunnyridge Cemetery		24D. LOCATION (City, town, or county) (State) Crisfield, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 10 1965		25B. NAME OF REGISTRAR Robert E. Stachura		25C. FUNERAL DIRECTOR Robert S. Brannon		25D. ADDRESS Severn Park, Md.	



FUNERAL DIRECTOR: IMPORTANT

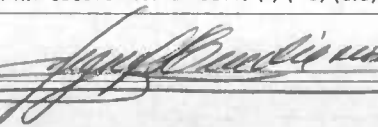
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2608				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2608	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Corrine Cook</b>				2. DATE AND HOUR OF DEATH <b>March 5, 1965 9:40 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE CORRECTED 3-16-65</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>10-01</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>1115 Proctor Street #21202</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>		8. DATE OF BIRTH <b>12-12-1917</b>	9. AGE (In years last birthday) <b>47</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Will Black</b>				14. MOTHER'S MAIDEN NAME <b>No Record</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORDS: BCH: 4940 Eastern Avenue #24</b>		ADDRESS	
18. <b>334X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pseudo Tumor Cerebri</b> <b>Pseudotumor Cerebr---</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) DUE TO				(B) DUE TO		(C) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR? HERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>March 3, 1965</b> to <b>March 5, 1965</b> , that (I) (we) lost saw the deceased alive on <b>March 5, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dr. M. Schuster</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>March 5, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. M. Schuster</b>				23D. ADDRESS M.D. <b>4940 Eastern Avenue Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/10/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Stanley</b>		25C. FUNERAL DIRECTOR <b>Edmund F. Bulluck</b>		ADDRESS <b>712-14 E. North Ave Baltimore, Md</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. <b>65 2609</b>		CERTIFICATE OF DEATH				Registered No. <b>65 2609</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WALDECKER, WILLIAM CARL</b>				2. DATE AND HOUR OF DEATH <b>3-9-65 3:50A</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 27</b> D. STREET ADDRESS (If rural, give location) <b>204 CLYDE AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>6-14-01</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Detective Co.</b>		11. BIRTHPLACE (State or foreign country) <b>WASH.D.C.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>CARL WALDECKER</b>				14. MOTHER'S MAIDEN NAME <b>GRACE MORROW</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes. 1917-1920</b>		16. SOCIAL SECURITY NO. <b>216-03-4834</b>		17. INFORMANT <b>ST. AGNES RECORDS - CATON &amp; WILKENS AVE</b> ADDRESS					
18. <b>490.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Auto Myocardial Infarction</b>						INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 7 1965</b> to <b>MARCH 9 19 65</b> , that (I) (we) last saw the deceased alive on <b>MARCH 9 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-9-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>ST. AGNES HOSPITAL</b>		23D. ADDRESS <b>ST. AGNES HOSPITAL</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/12/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTO. NAT. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 10 1965</b>		25B. NAME OF REGISTRAR <b>R. G. ESTERLINE</b>		25C. FUNERAL DIRECTOR <b>EDWARD SCHWAB</b>		ADDRESS <b>3512 FREDERICK AVE. (29)</b>			



AGE:

DATE BIRTH:

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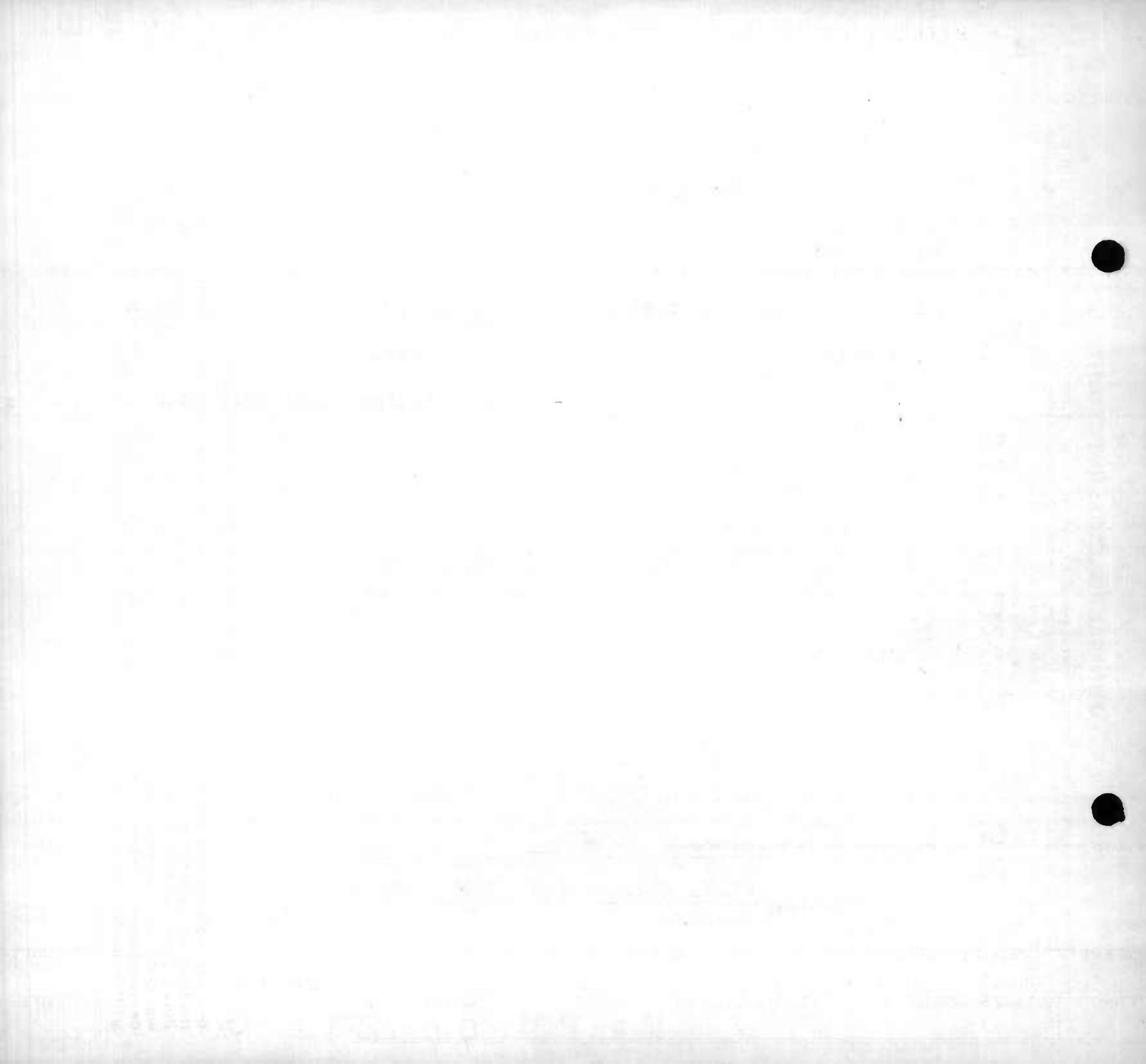
1921

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

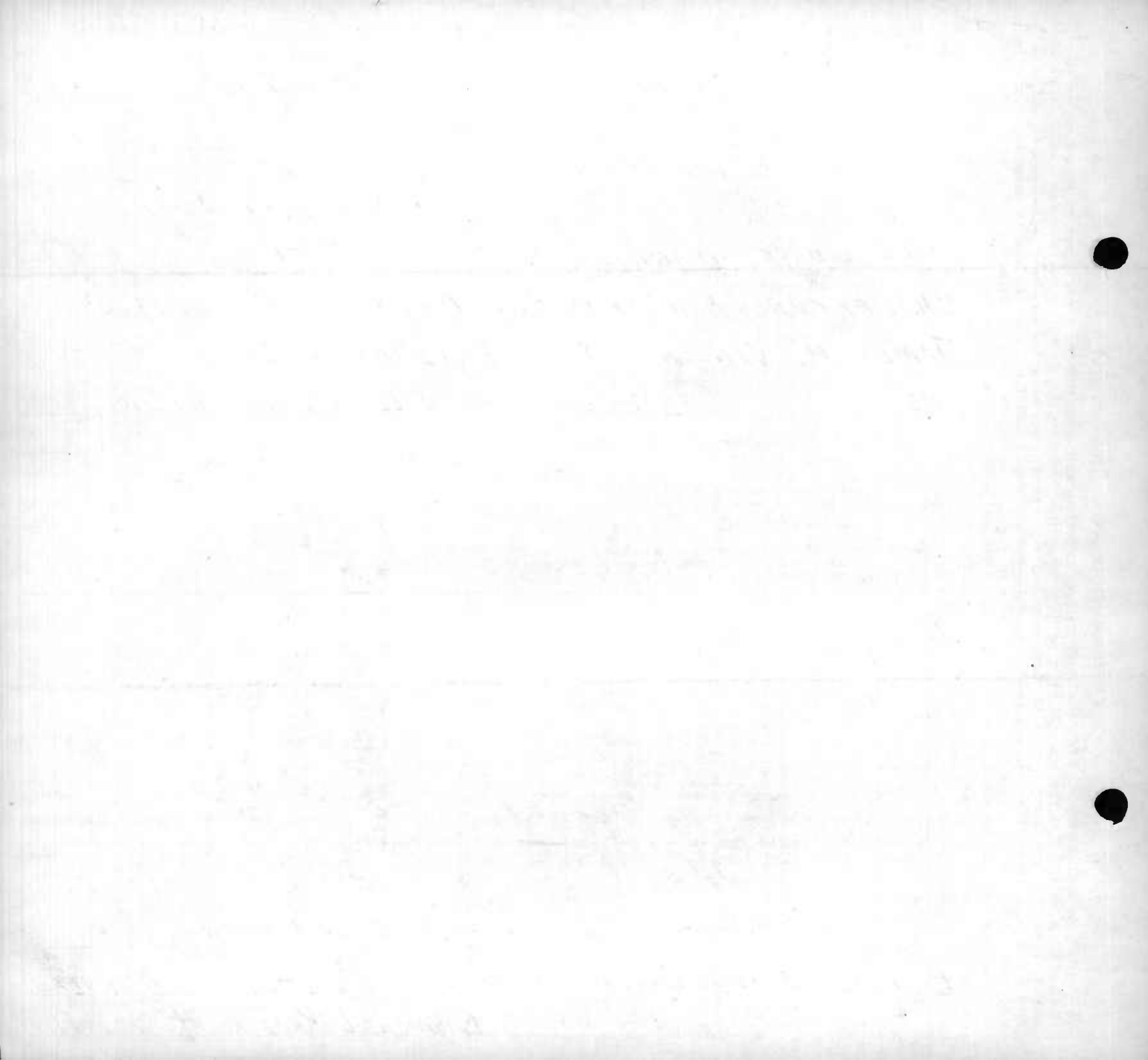
BIRTH NO. 65 2610				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2610	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
JOHN J MARTIN				MARCH 7, 1965		9 <sup>10</sup> P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
2822 Loch Raven Road				Maryland		7-04	
5. SEX				6. RACE			
Male				White			
7. MARRIED, NEVER MARRIED				8. DATE OF BIRTH			
WIDOWED, DIVORCED (specify)				April 24 1882			
9. AGE (In years last birthday)				82			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Railway operator				Baltimore Md			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
Street Car				U S A			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
? Martin				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				213-05-9916			
17. INFORMANT				ADDRESS			
Mr William Woods				2822 Loch Raven Rd			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) Left hemiplegia			
ANTECEDENT CAUSES				(B) Bronchopneumonia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Senility			
II				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				2-3 wks.			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
0							
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 2 1965 to Mar 2 1965, that (I) (we) last saw the deceased alive on Mar 2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Theodore J. Graziano M.D.				3/9/65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Theodore J. Graziano M.D.				2802 Harford Rd 21218.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				3/11/65			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Baltimore Cemetery				Baltimore Md			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
MAR 10 1965				Robert E. Taylor M.D.			
25C. FUNERAL DIRECTOR				ADDRESS			
J. Melville Jenkins				2713 Kirk Ave			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2611				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2611	
M.E. CASE NO. 65 2611				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JAMES HARRISON VINSON</b>				2. DATE AND HOUR OF DEATH <b>MARCH 9 1965 6 A. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>700 S. MONTFORD AVE.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>700 S. MONTFORD AVE.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>7-1-13</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ASSOC. OF MD. PILOTS</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JAMES H. VINSON</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH LEGG</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-10-6839</b>		17. INFORMANT ADDRESS <b>MRS. LILLIAN VINSON 700 S. MONTFORD AVE.</b>			
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Coronary Thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Arteriosclerosis of aorta</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO <b>Acute Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>March 8, 1965</b> to <b>March 9, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 8, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>I. J. FENGLOS M.D.</b>				23B. DATE SIGNED <b>3/10/65</b>		23C. PHYSICIAN'S NAME (Type) <b>I. J. FENGLOS M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-12-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>OAKLAWN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>RAYMOND L. KACZOROWSKI 2525 FLEETS</b>			



BALTIMORE CITY HEALTH DEPARTMENT

65 2612

BIRTH NO. 65 2612 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) **FREDERICK HEIGHT**

2. DATE AND HOUR PRONOUNCED DEAD **March 6, 1965** **8:40 A.** M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland**

B. COUNTY \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **703 Y Alley**

5. SEX **Male**

6. RACE **Negro**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Never**

8. DATE OF BIRTH **5-29-1895**

9. AGE (In years last birthday) **73**

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired**

10B. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_

11. BIRTHPLACE (State or foreign country) **Calvert Co., Md.**

12. CITIZEN OF WHAT COUNTRY? \_\_\_\_\_

13. FATHER'S NAME **Alonza Height**

14. MOTHER'S MAIDEN NAME **Altheria ?**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) \_\_\_\_\_

16. SOCIAL SECURITY NO. \_\_\_\_\_

17. INFORMANT **Mable Smith-703 Y Alley** ADDRESS \_\_\_\_\_

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

**Arteriosclerotic cardiovascular disease**

(A) DUE TO \_\_\_\_\_

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO \_\_\_\_\_

(C) \_\_\_\_\_

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION \_\_\_\_\_

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED \_\_\_\_\_

20A. AUTOPSY? (Yes or No) **No**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? \_\_\_\_\_

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. ☐ UNDERLYING ☐ CONTRIBUTING

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) \_\_\_\_\_

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) \_\_\_\_\_

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **John E. Adams** M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) **John E. Adams, M.D.** ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **3-6-65**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial**

23B. DATE **3-10-65**

23C. NAME OF CEMETERY or CREMATORY **Baltimore National**

23D. LOCATION (City, town, or county) (State) **Baltimore City**

24A. DATE REC'D BY HEALTH DEPT. **MAR 10 1965**

24B. NAME OF REGISTRAR **Isaiah L. Brown & son**

24C. FUNERAL DIRECTOR **Isaiah L. Brown & son**

24D. ADDRESS **108 W. Montgomery St.**

VALLEY BOULE

PROBATION

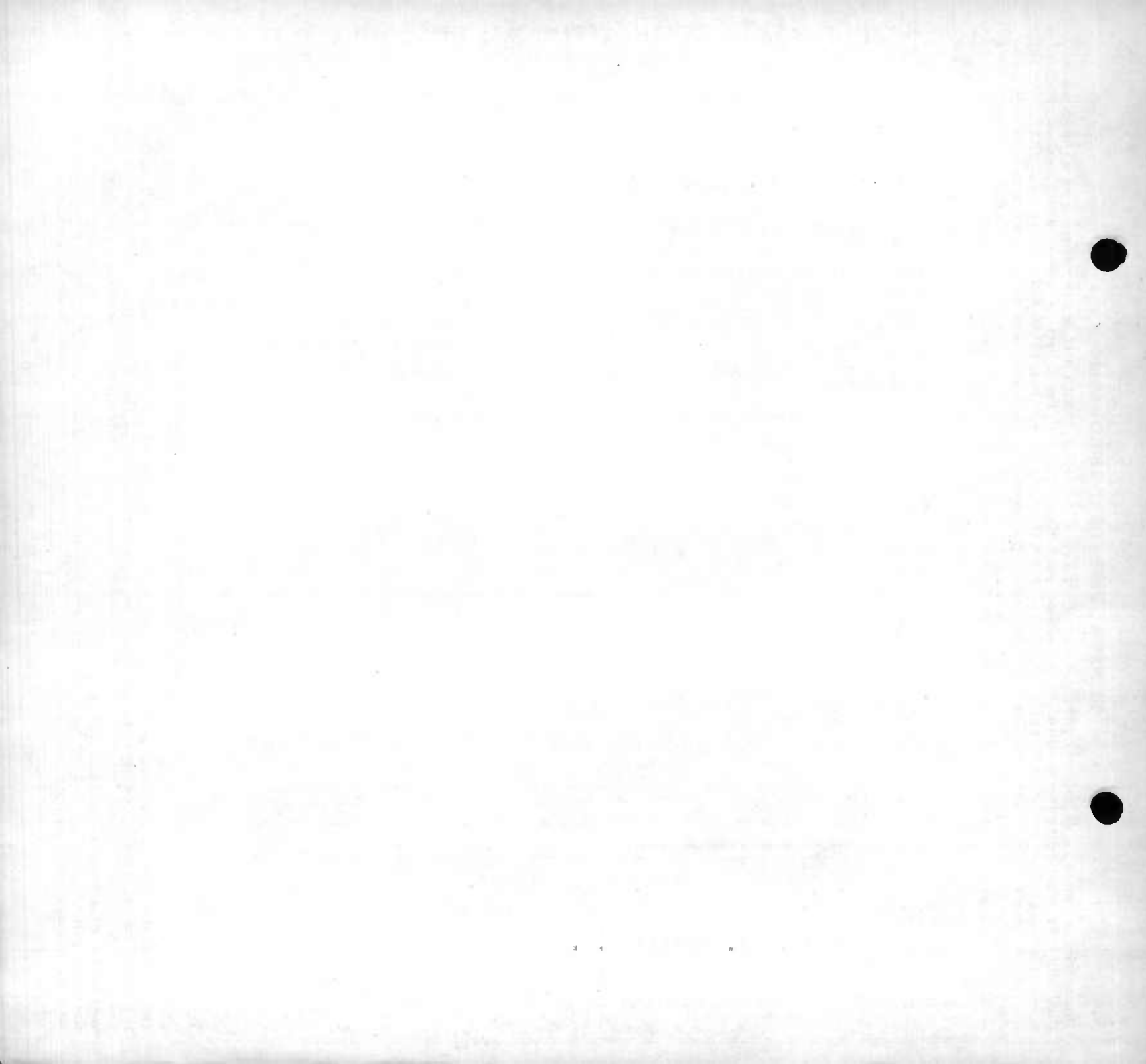
EX-1



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

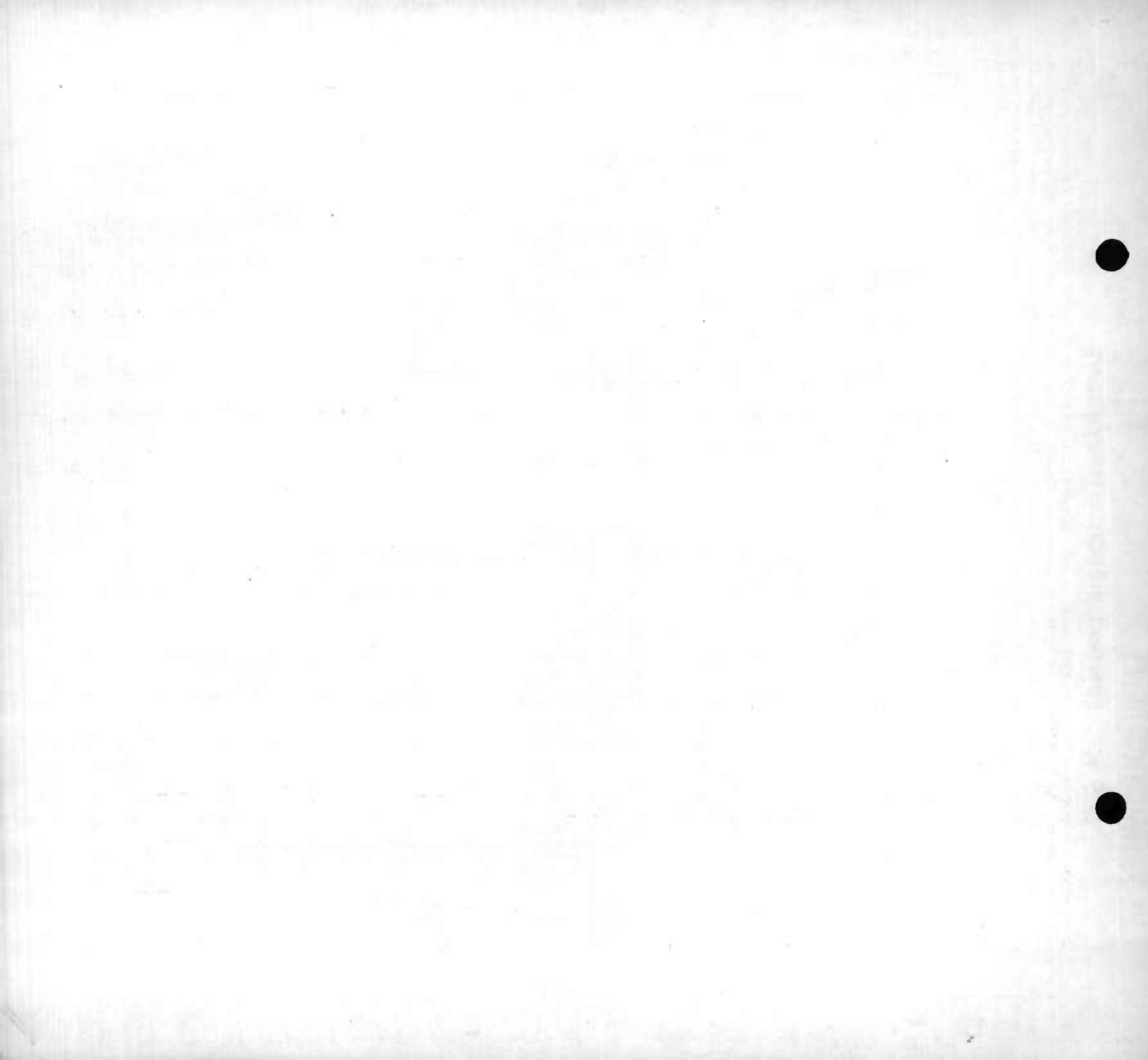
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2613	
BIRTH NO. 65 2613		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) VANCE, JOSEPH		2. DATE AND HOUR OF DEATH 3/9/65 12:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSP		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 631 HOUSER STREET 2202	
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 8/2/01	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME JOSEPH VAN		14. MOTHER'S MAIDEN NAME MARY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS	
18. 593X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Renal Failure (B) Hypertension (C)		INTERVAL BETWEEN ONSET AND DEATH 16 days 2-16 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CVA STUPOROUS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/12 1965 to 3/9 1965, that (I) (we) last saw the deceased alive on 2/8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dominic A. Culotta M.D.		23B. DATE SIGNED 3/9/65		23C. PHYSICIAN'S NAME (Type) DOMINIC A. CULOTTA M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/12/65		24C. NAME OF CEMETERY or CREMATORY Mt Calvary	
24D. LOCATION (City, town, or county) Baltimore		24E. (State) Md		25A. DATE REC'D BY HEALTH DEPT. MAR 10 1965	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles A. Roe		25D. ADDRESS 6614 Barre	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Geraldine Mitchell		3-1-65 12:05 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224			A. STATE Maryland B. COUNTY Baltimore		
5. SEX Female			6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2-28-1925
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday) 40
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
17. INFORMANT			ADDRESS		
RECORDS: B.C.H. 4940 Eastern Avenue #21224					
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Hepatic Renal Failure (B) Cirrhosis (C) Chronic Alcoholism					1 Month 3 Years 5 Years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-9-19 65 to 3-1-19 65, that (I) (we) last saw the deceased alive on 3-1-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Douglas G. Carroll				23B. DATE SIGNED 3-1-65	
23C. PHYSICIAN'S NAME (Type) Dr. Douglas G. Carroll				23D. ADDRESS 4940 Eastern Avenue #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) MAR 10 1965		24B. NAME OF CEMETERY or CREMATORY CARETOWN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 10 1965		25B. NAME OF REGISTRAR Robert E. Fink, M.D.		25C. FUNERAL DIRECTOR 2 MORTUARY SERVICE - BCHA	



## CERTIFICATE OF DEATH

Registered No.

65 2615

65 2615

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Irma Johnson

2. DATE AND HOUR OF DEATH

February 20, 1965 6:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

214 E. 20th. Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

8-15-22

9. AGE (In years  
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Tennessee

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18. 581.01

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Pneumonia & Congestive Heart Failure 1 week  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) Hepatic Cirrhosis 2 years  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from October 11, 1964 to February 20, 1965,  
that (I) (we) last saw the deceased alive on February 20, 1965 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Douglas Carroll

M.D.

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

2-20-65

23C. PHYSICIAN'S  
NAME (Type)

Douglas Carroll

M.D.

23D. ADDRESS

4940 Eastern Avenue 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

MAR 10 1965

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 10 1965

25B. NAME OF REGISTRAR

Robert E. Taylor

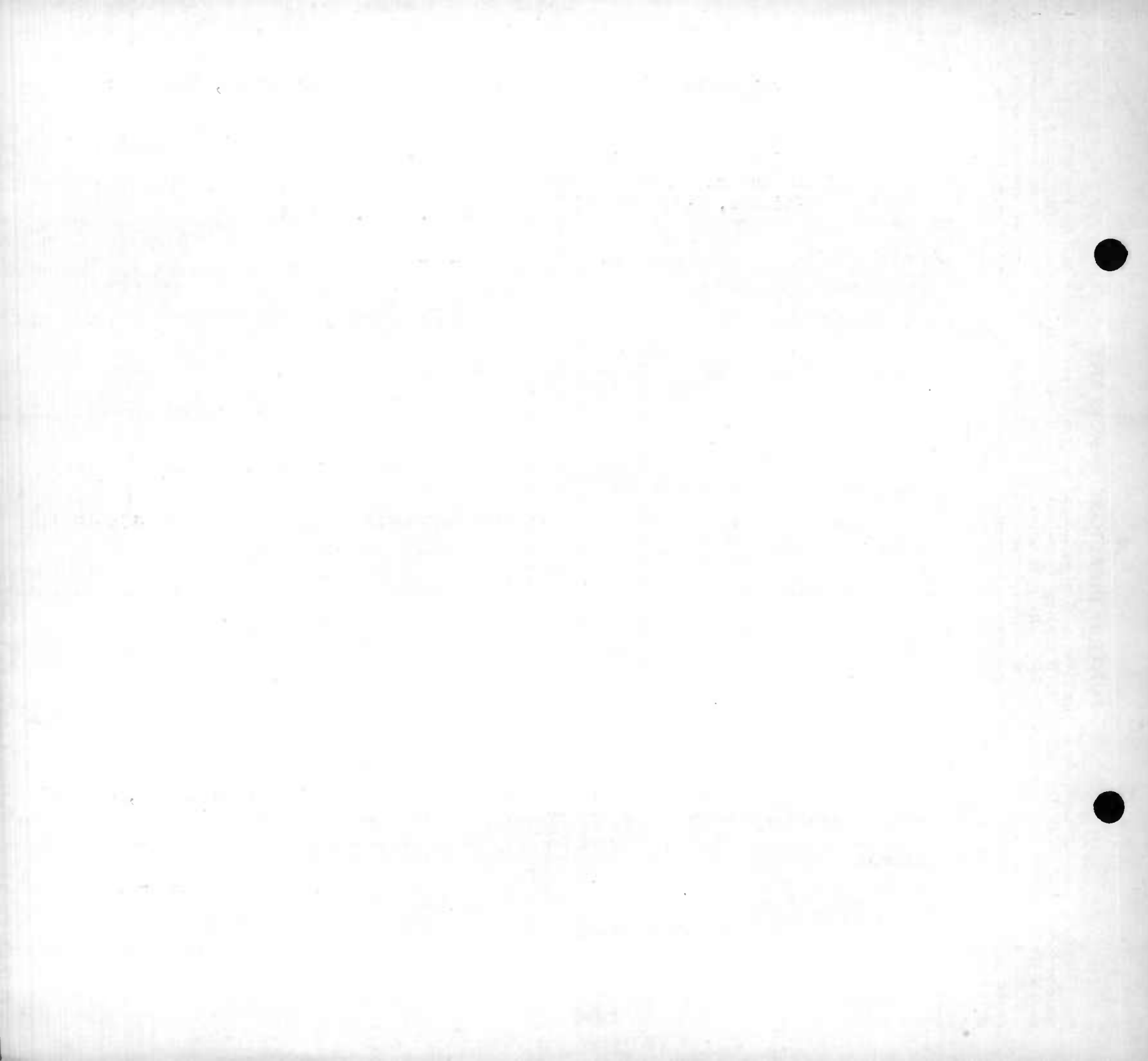
25C. FUNERAL DIRECTOR

2MORTUARY SERVICE - BCHD

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2616	
BIRTH NO. 65 2616		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) James CARTER		2. DATE AND HOUR OF DEATH 3-6-65 1:20 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital		A. STATE Maryland B. COUNTY 17-03			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 703 N. Lanvale Street			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH Sept 2, 1907	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Abbeyville South Carolina	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME North Carter		14. MOTHER'S MAIDEN NAME Martha Towns			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Hill Carter brother 1205 Poplar Lane	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Bronchial Arterio		INTERVAL BETWEEN ONSET AND DEATH 28 days.	
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Rt heart failure		8 mos	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 14, 1965 to 2/7/65 1965, that (I) (we) last saw the deceased alive on 2/1/65 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lucius W. Zeeper M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 3-10-65	
23C. PHYSICIAN'S NAME (Type) Lucius W. Zeeper		23D. ADDRESS 1200 Bloomingdale Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE March 10, 1965	24C. NAME OF CEMETERY or CREMATORY Mt Zion Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 10 1965		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Joseph L. Russ 2222 N. North Ave (16)	



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65-01977

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 2617 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2617

M-532

42  
99

1. NAME OF DECEASED (Type or Print)		RUDONNA MONTGOMERY		2. DATE AND HOUR PRONOUNCED DEAD 3-8-65 12:28 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL - DOA		A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-12			
		D. STREET ADDRESS (If rural, give location) 3623 Reisterstown Road 21215			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 1-26-1965	9. AGE (In years last birthday) 6 weeks	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md	
13. FATHER'S NAME Rudolph A. Montgomery		14. MOTHER'S MAIDEN NAME Marie Rice			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service no		16. SOCIAL SECURITY NO.		17. INFORMANT Marie Montgomery - 3623 Reisterstown Rd	
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) PNEUMONITIS DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-8-65	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3-11-65		23C. NAME OF CEMETERY or CREMATORY Balto National	
24A. DATE REC'D BY HEALTH DEPT. MAR 10 1965		24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR Purnell S. Edin - Balto. Md	
		24D. ADDRESS			

VS 151-REV. 1/1/65

1-24-1943

State 2014

Miss Rice

Miss Montgomery

Miss A. Montgomery  
200

Miss A. Montgomery

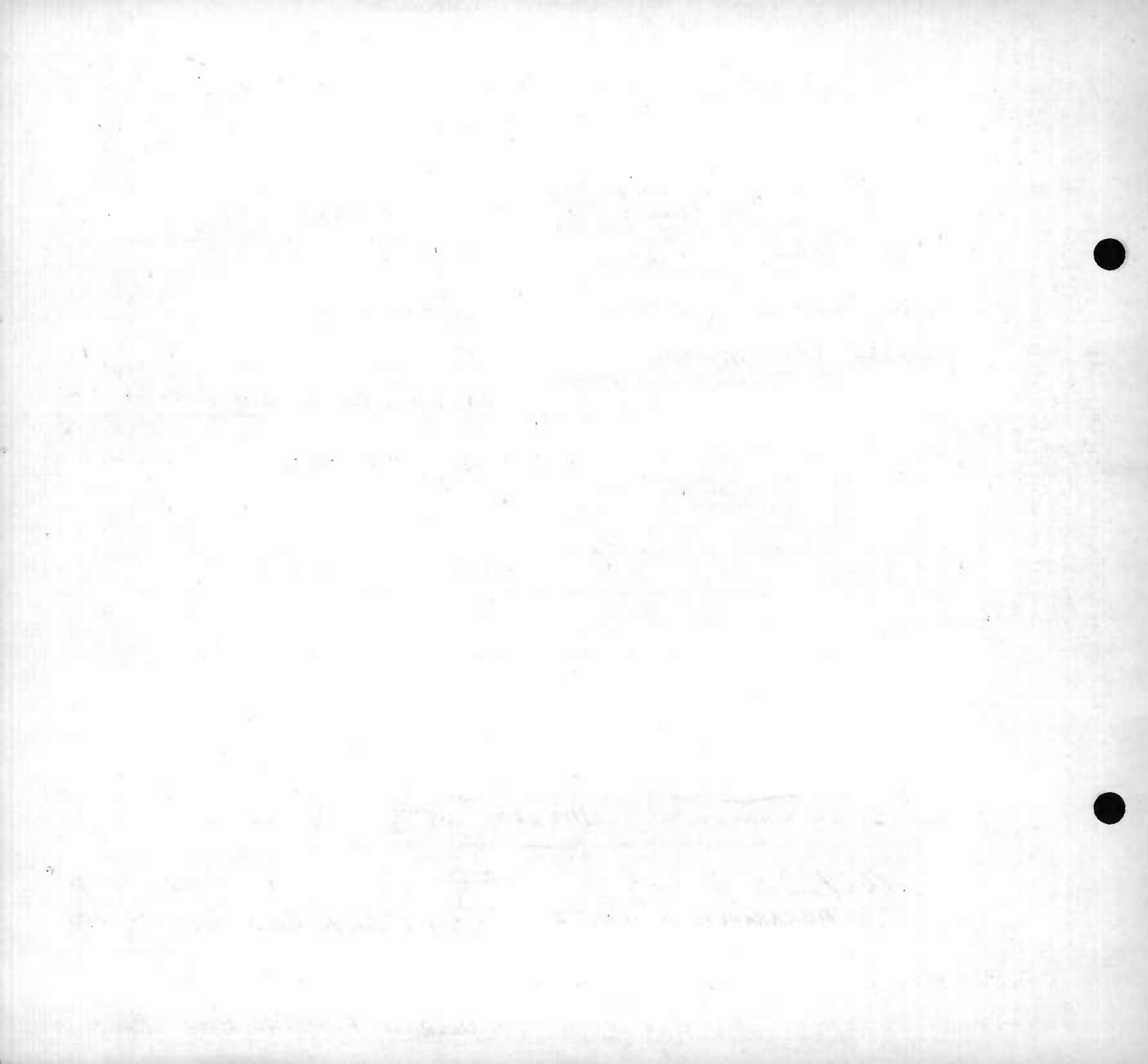
Miss A. Montgomery

Miss A. Montgomery

# FUNERAL DIRECTOR: IMPORTANT

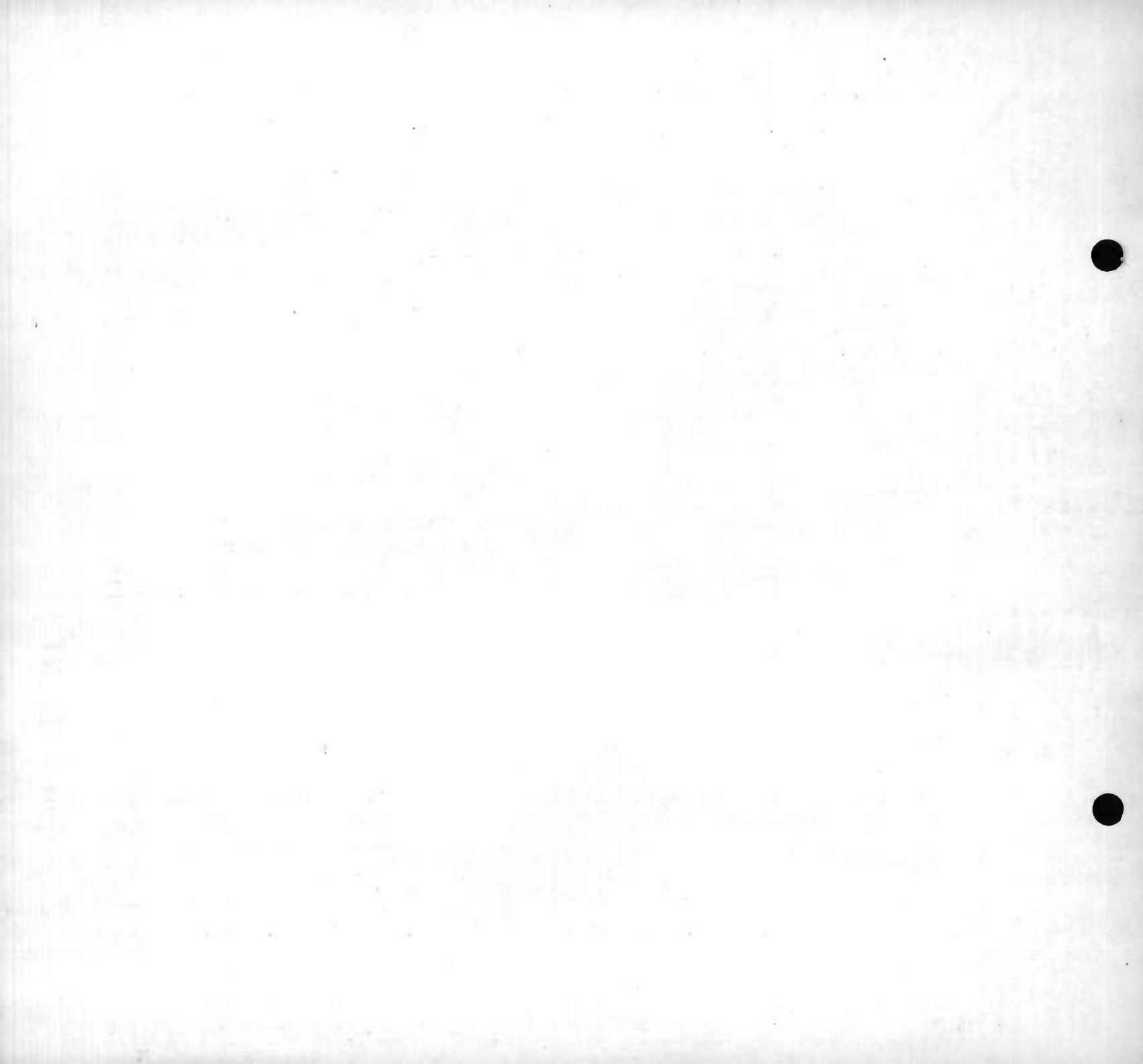
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2618				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2618	
1. NAME OF DECEASED (Type or Print) <b>GEORGE WILLIAMSON</b>				2. DATE AND HOUR OF DEATH <b>MARCH 7 1965 8:00 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MO.</b> B. COUNTY <b>27-02-0019</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Mount Convalescent Home 3706 Norton Road Baltimore, Md.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>3111 MORAVIA AVE.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>1-9-91</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WIRE DRAWER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE WILLIAMSON</b>				14. MOTHER'S MAIDEN NAME <b>—</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. FRANK CARNES 3111 MORAVIA AVE.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b> <b>coronary thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>Nov. 19 1964</b> to <b>March 7 1965</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>March 2 1965</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Abraham B. Hurwitz</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>March 7, 1965</b>			
23C. PHYSICIAN'S NAME (Type) <b>ABRAHAM B. HURWITZ</b> M.D.				23D. ADDRESS <b>7501 Liberty Road, BALTO. 7, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-10-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>oak lawn</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. Co., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR ADDRESS <b>VALRICHA FUNERAL HOME BALTO., MD.</b>			



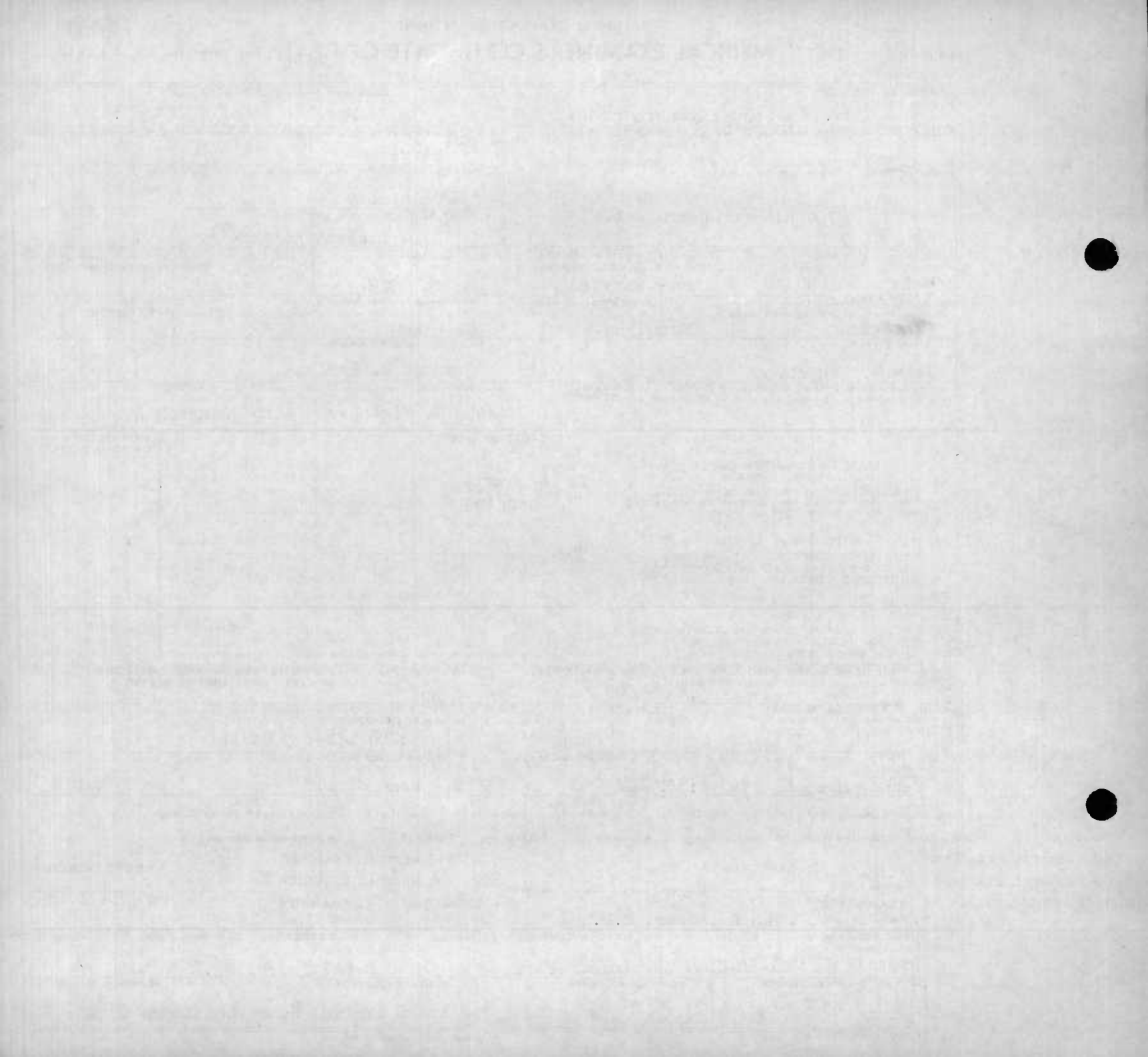
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65





BIRTH NO. 65 2620		BALTIMORE CITY HEALTH DEPARTMENT		65 2620	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
John Eigenbrodt			March 6, 1965 5:15 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE		
3704 Liberty Heights Ave.			Maryland		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			3704 Liberty Heights Ave.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.
Male	White	Never Married	May 5, 1937	27	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Teacher			Maryland		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
Education			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John G. Eigenbrodt			Frances M. Perina		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT ADDRESS		
			John G. Eigenbrodt 4219 Shamrock Ave 21206		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) Asphyxia		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			DUE TO hanging		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		no			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
	home	3704 Liberty Heights Ave.			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
Found Mar. 6, 1965 4:30P	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	hanged self			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)			DATE SIGNED		
John E. Adams, M.D.			Mar. 7, 1965		
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)		
Burial	1-10-65	Loudon Park	Baltimore, Md.		
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS			
MAR 10 1965	Robert E. Eigenbrodt	Ullrich Funeral Home Baltimore 6, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

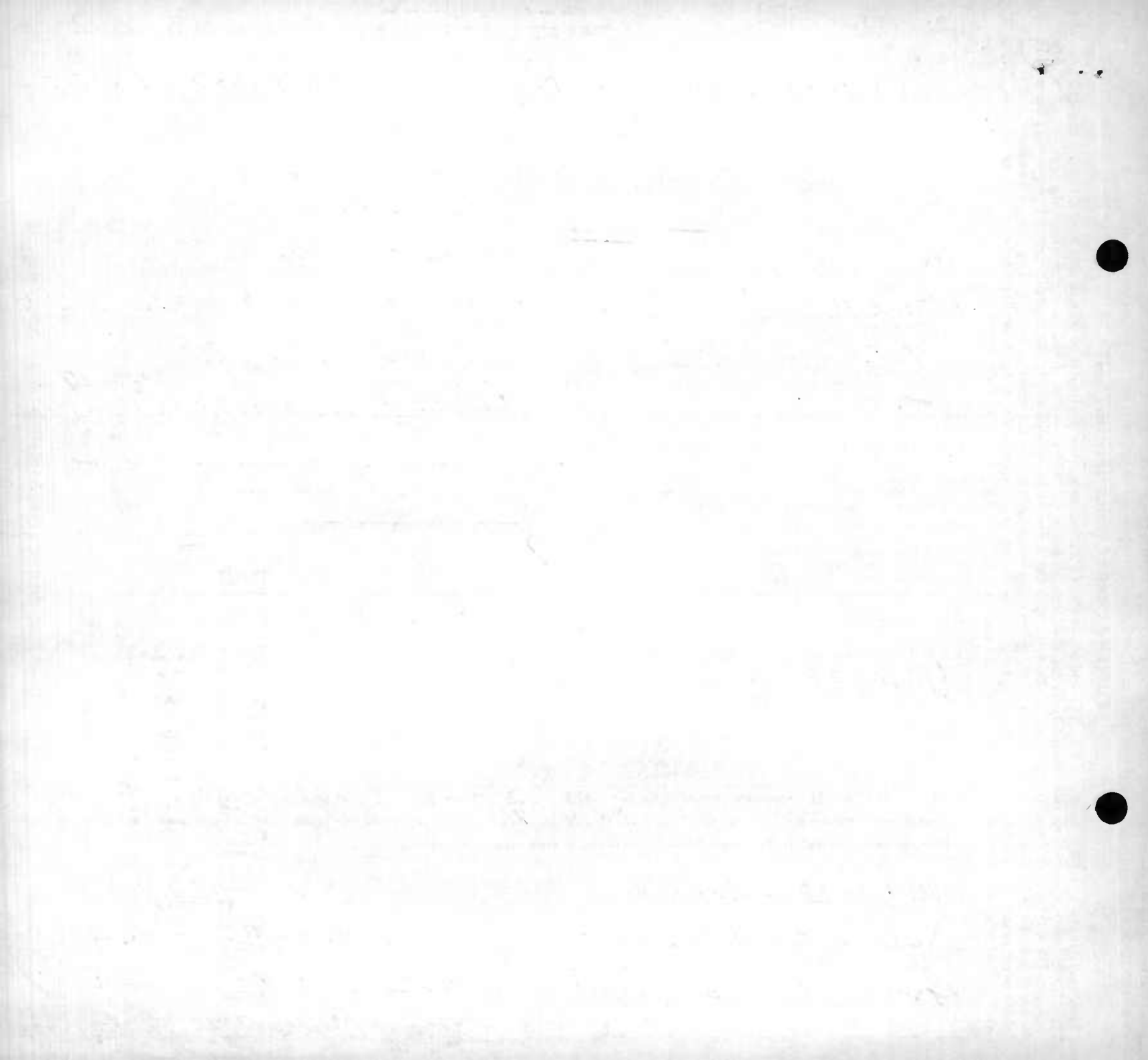
BIRTH NO. 65 2621		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2621	
1. NAME OF DECEASED (Type or Print) ADA ESTEP DAVIS			2. DATE AND HOUR OF DEATH Mar 4-65 3:P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) W. 831 Franklin Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 17-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 831 Franklin		
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Seperated	8. DATE OF BIRTH 6-12-1907	9. AGE (In years last birthday) 57	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (State or foreign country) A.A.Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Wesley Estep			14. MOTHER'S MAIDEN NAME Addie Smith		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT ADDRESS Aletha Colbert-15 Carver St. Anna. Md.		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Anterior sclerotic Arterio vascular disease UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb. 22, 1965 to March 5, 1965, that (I) (we) last saw the deceased alive on March 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William H. Watts M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 3-5-65	
23C. PHYSICIAN'S NAME (Type) William H. Watts		23D. ADDRESS 575 N. A. P.ington, N. B. 20, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Mar. 9-65	24C. NAME of CEMETERY or CREMATORY Tayler	24D. LOCATION (City, town, or county) (State) Deale, Maryland		
25A. DATE REC'D BY HEALTH DEPT. MAR 10 1965		25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR C.E. Hicks		ADDRESS 111 Annapolis, Md.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2622		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2622	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Pindell, Morris R.</i>		2. DATE AND HOUR OF DEATH <i>MARCH 7 1965 12:05 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>15-38</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital of Balto</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 15.</i>			
		D. STREET ADDRESS (If rural, give location) <i>3017 Chelsea Terr.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. <del>MARRIED</del> <i>WIDOWED</i> (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>11-24-81</i>	9. AGE (In years last birthday) <i>83</i>	10. Under 1 Yr. Months Days   11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired messenger</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bank</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland - (Balto.)</i>	
12. CITIZEN OF WHAT COUNTRY? <i>AMERICAN (USA)</i>		13. FATHER'S NAME <i>Richard Pindell</i>		14. MOTHER'S MAIDEN NAME <i>Rose Bull</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>215-09-1969</i>		17. INFORMANT <i>Mrs Rose Fried</i>	
18. <i>670X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Gram Negative Septicemia</i> DUE TO <i>Shock (Aerobacter)</i> (B) <i>Pneumonia</i> DUE TO (C)		ADDRESS <i>Zone 7</i> <i>3701 Villa Nova Road</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Generalized ASCVD</i>					
19A. DATE OF OPERATION <i>March 2/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Benign Prostatic Hyperplasia</i>		20A. AUTOPSY? (Yes or No) <i>—</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2-24</i> 19 <i>65</i> to <i>March 7</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>March 7</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Venerando J. Maximo</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3-7-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Venerando J. Maximo</i>		23D. ADDRESS M.D. <i>Sinai Hospital of Balto</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-10-1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Landon Park Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 10 1965</i>			
25B. NAME OF REGISTRAR <i>R. E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Erving Byers</i>			
25D. ADDRESS <i>8728 Liberty Road</i>		<i>Randallstown, Md.</i>			



BIRTH NO.

65 2623

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2623

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HERMAN MAAS

2. DATE AND HOUR PRONOUNCED DEAD

March 6, 1965

2:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3203 W. Belvedere Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11/21/1895

9. AGE (In years  
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired Baker (Guard)

10B. KIND OF BUSINESS OR INDUSTRY

Pimlico Race Track

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

215-01-8898

17. INFORMANT

ADDRESS

Julia M. Maas 3203 W. Belvidere Ave. Balt 15

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular  
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-6-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/9/65

23C. NAME OF CEMETERY or CREMATORY

Druid Ridge Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 10 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Loring Byers 8728 Liberty Rd. Randallstown  
Md.

ADDRESS



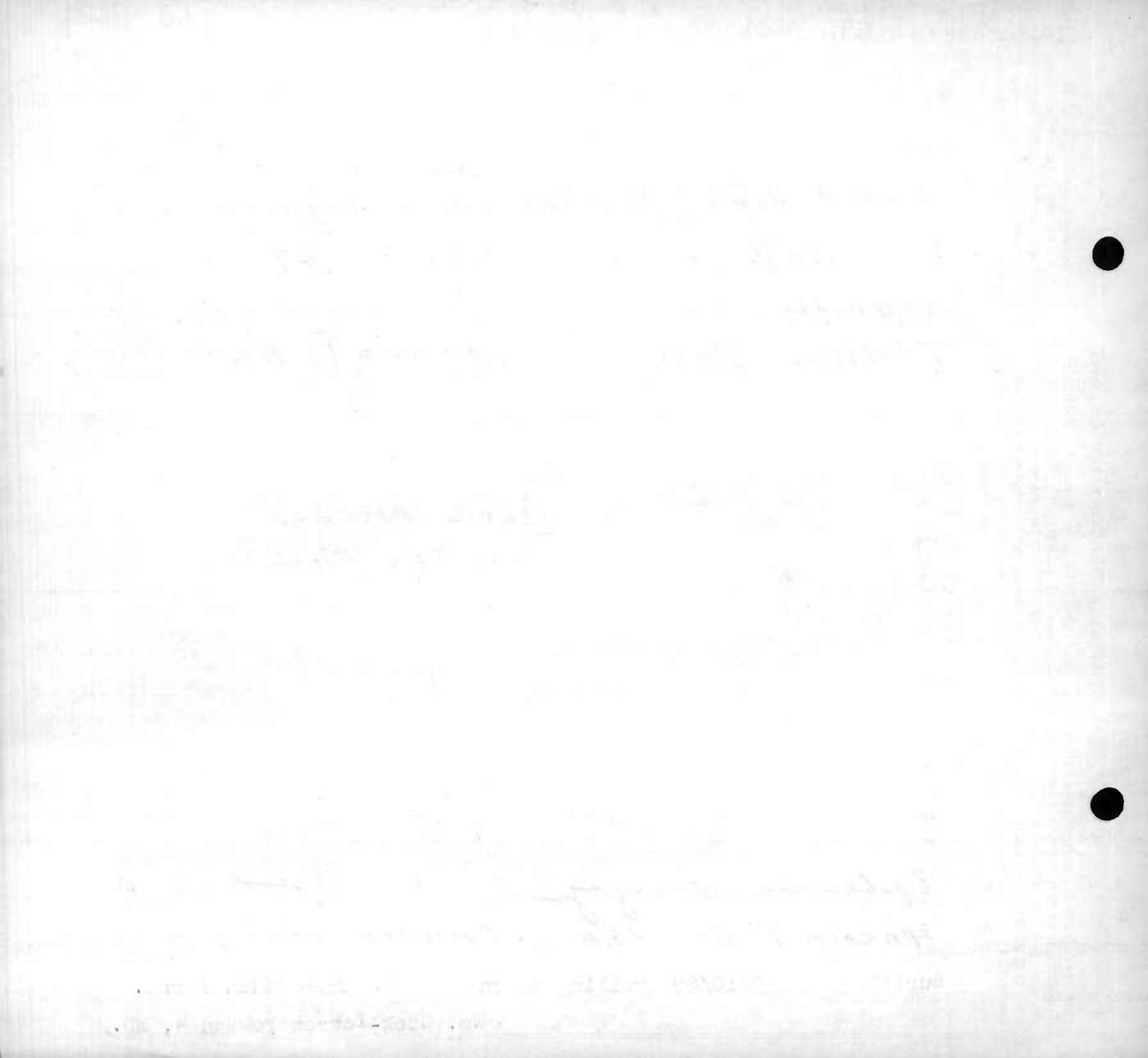
VALLEY POLICE



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2624		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2624	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BAIR, LOIS		2. DATE AND HOUR OF DEATH 3-8-65 4:20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY md 2008			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH Home & Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 233 S. ANGSTA AVE.			
5. SEX F.	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 1898 FEB 11 67	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PA. BEDFORD	
13. FATHER'S NAME Thaddens BAIR		14. MOTHER'S MAIDEN NAME HARRIET ARMSTRONG		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 199-2x1 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) CARCINOMATOSIS DUE TO (B) PELVIC ABSCESS DUE TO (C) DIABETES MELLITUS		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-6 1965 to 3-8 1965, that (I) (we) last saw the deceased alive on 3-8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ephraim Barzaga M.D.		23B. DATE SIGNED 3-8-65		23C. PHYSICIAN'S NAME (Type) Ephraim B. BARZAGA M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/10/65		24C. NAME OF CEMETERY or CREMATORY Rolling Green	
25A. DATE REC'D BY HEALTH DEPT. MAR 10 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Wm. Cook-Towson Towson 4, MD.	



K500

65 2625

BALTIMORE CITY HEALTH DEPARTMENT

65 2625

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM JOSEPH KENNEY

2. DATE AND HOUR PRONOUNCED DEAD

3-8-65

12:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

613 E. BALTIMORE STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

613 E. Baltimore Street 21202

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Divorced

8. DATE OF BIRTH

Feb. 15, 1909

9. AGE (In years  
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Joseph D. Kenney

14. MOTHER'S MAIDEN NAME

Mary A. Burrier

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

James L. Kenney, 637 E. 35th Street, Zone 18

18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				
(A) <u>Pulmonary emphysema with broncho-</u> <u>pneumonia</u>				
(B) <u>Cirrhosis of liver</u> DUE TO				
(C) _____				
<b>II</b>				
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
2				Yes - Par
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
PETER W. RIECKERT, M.D.		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY
BURIAL		3-11-65		Holy Redeemer Cemetery
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR
MAR 10 1965		Robert E. Farley, M.D.		Wm. Cook, Inc., 1217 St. Paul Street, 21202
				ADDRESS

WALLACE

1800

5-536 65 2626 BALTIMORE CITY HEALTH DEPARTMENT 65 2626

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) WILLIAM H. SONDERMAN

2. DATE AND HOUR PRONOUNCED DEAD 3-8-65 3:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-03

D. STREET ADDRESS (If rural, give location) 2521 Oliver Street 21213

5. SEX Male

6. RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married

8. DATE OF BIRTH Dec. 5, 1891

9. AGE (In years last birthday) 73

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Philip H. Sonderman

14. MOTHER'S MAIDEN NAME Elizabeth Dahnker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. 215-03-7221

17. INFORMANT ADDRESS Mrs Ella Sonderman, 2521 East Oliver Street

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

(A) Gastro-intestinal hemorrhage

(B) Complicating congestive heart failure and diabetes mellitus

(C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes Partial

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

ASSOCIATE MEDICAL EXAMINER

DATE SIGNED 3-8-65

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL

23B. DATE 3-11-65

23C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery

23D. LOCATION (City, town, or county) (State) Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT. MAR 10 1965

24B. NAME OF REGISTRAR Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR ADDRESS Wm. Cook, Inc., 1217 St. Paul Street, 21202

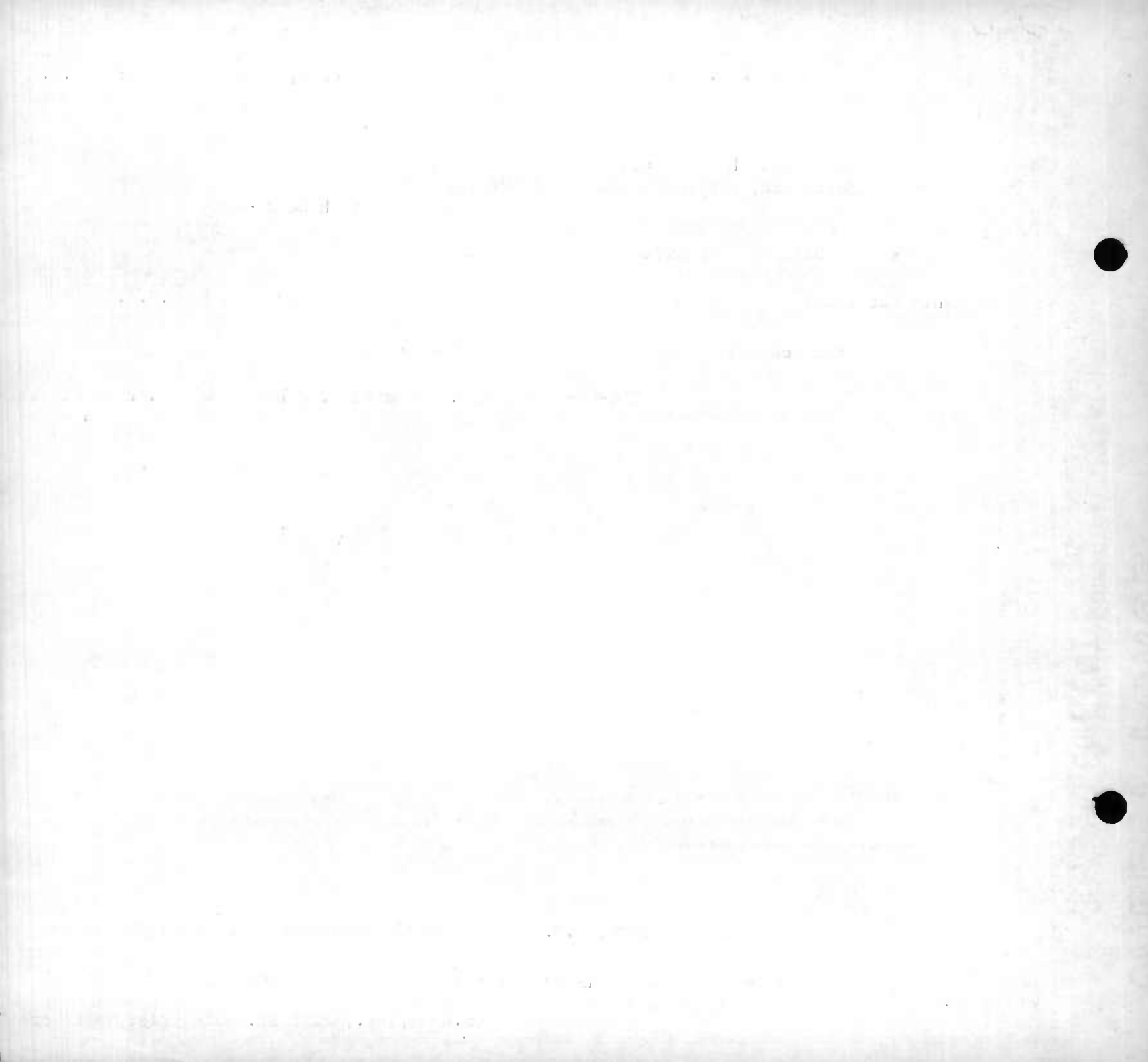
Handwritten signature or initials, possibly "H. H. H."



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2627				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2627	
1. NAME OF DECEASED (Type or Print) Joseph A. Schmuck				2. DATE AND HOUR OF DEATH March 8, 1965		7:10 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2417 East Chase Street Baltimore, Maryland 21213				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21213 D. STREET ADDRESS (If rural, give location) 2417 East Chase Street			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH June 16, 1887	9. AGE (In years birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Carpenter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Schmuck				14. MOTHER'S MAIDEN NAME Louise Bopp			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-01-8829		17. INFORMANT ADDRESS Mrs. Margaret E. Schmuck, 2415 E. Chase Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Pulmonary Tuberculosis (B) DUE TO Emphysema of the Lungs (C) DUE TO Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH March 8, 1965 He was taken to hospital Jan 16-65	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input checked="" type="checkbox"/>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) X		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? X			
22. I certify that (I) (this hospital) attended the deceased from Jan 15 1965 to approx 7.0 19 65, that (I) (we) last saw the deceased alive on March 7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE F. Ruzicka				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED March 10/65	
23C. PHYSICIAN'S NAME (Type) Frederick Ruzicka, M.D. M.D.				23D. ADDRESS 800 North Patterson Park Avenue, Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-11-65		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 10 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm. Cook, Inc.,		ADDRESS 1217 St. Paul Street, Baltimore	





P-200

BIRTH NO. 65 2628		BALTIMORE CITY HEALTH DEPARTMENT		65 2628	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
Alphonso Pack		Mar. 6, 1965 10:45 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland			
Johns Hopkins Hospital		B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		3407 Duvall Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	Negro	Married	8-13-1913	51	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Operator		Chemical Co.		Balto. Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Marion Pack		Mary Jemerson		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES W.W. #2		219-01-4780		Hannah Pack 3407 Duvall Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Arteriosclerotic Cardiovascular disease		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
John E. Adams, M.D.				Mar. 7, 1965	
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER			
John E. Adams, M.D.					
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial		3-11-65		National Cmt. Baltimore 28, Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
MAR 10 1965		Robert E. Taylor, M.D.		Randolph J. Collick 1412 E. Preston St.	

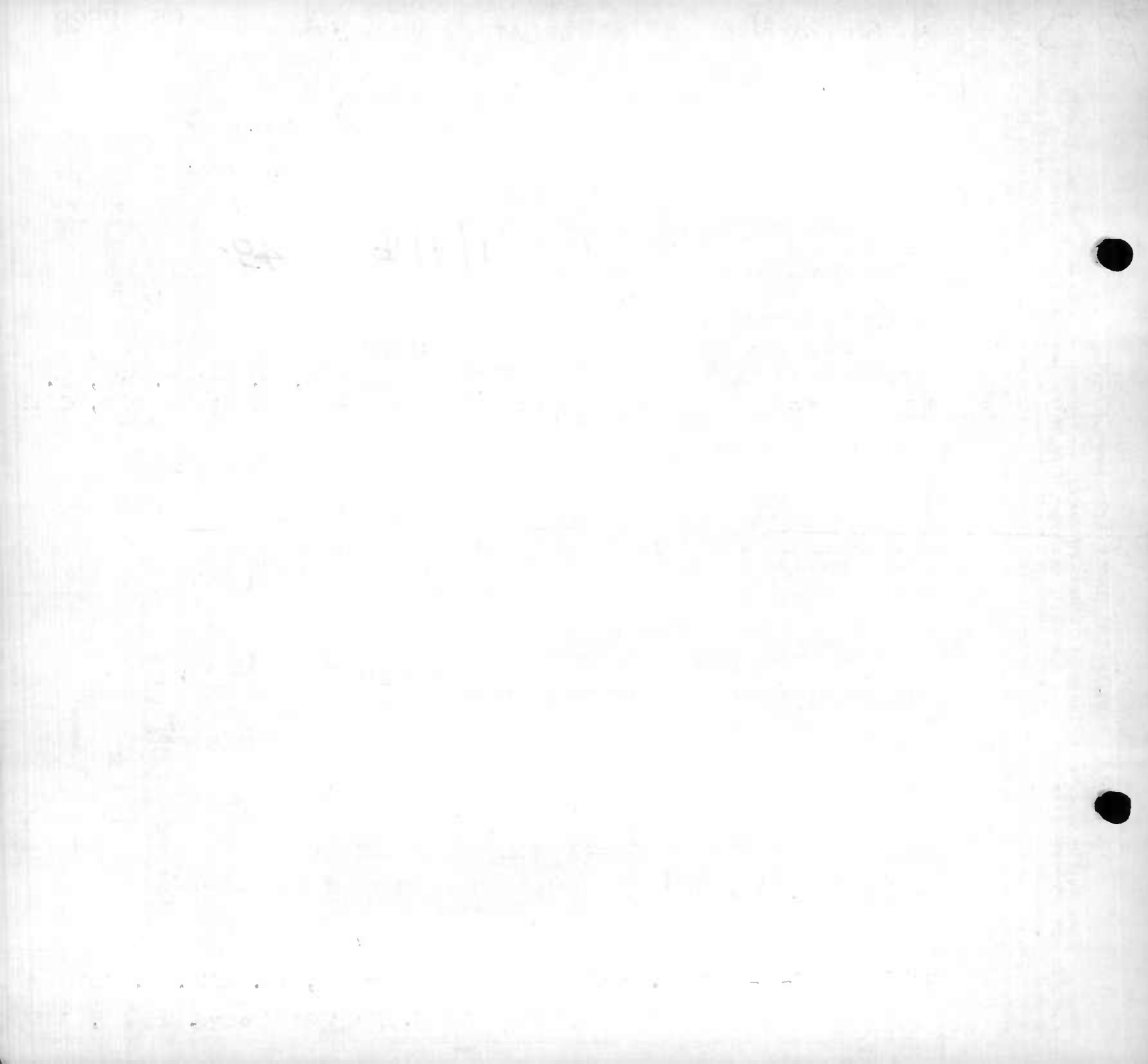
Yes W.W.R. - 21-11-12  
Morton Park  
Chemical Co. 21-11-12  
21

Bureau 2-11-12  
Ralph D. Dodge

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2629		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2629	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Print or Print) Lillie Frances Huth		6 March 65		7:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University of Md. Hospital		A. STATE Md.		B. COUNTY Baltimore	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Dundalk 53-00			
		D. STREET ADDRESS (If rural, give location) 115 Bayside Drive		vrvvv	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 1/4/16	9. AGE (in years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Stefan Kuta		14. MOTHER'S MAIDEN NAME Agnes Maylaka		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-6702		17. INFORMANT Husband, Mr. Louis G. Huth, Sr. Hospital Record 115 Bayside Drive, 21222	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 237X I		CAUSE OF DEATH (A) Cerebral anoxia DUE TO (B) Cardiac arrest DUE TO (C) Convulsions due to brain tumor		INTERVAL BETWEEN ONSET AND DEATH 10 days 10 days Several months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gangrene rt. arm					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 2/24/65 to 6 March 1965, that (I) (we) last saw the deceased alive on 6 March 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Roberto A. Negrón, M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6 March 65	
23C. PHYSICIAN'S NAME (Type) Roberto A. Negrón, M.D.		23D. ADDRESS M.D. Univ. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-10-1965		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus	
24D. LOCATION Dundalk, Ave. Balto. Md. 21224		24E. DATE REC'D BY HEALTH DEPT. MAR 10 1965		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. FUNERAL DIRECTOR JOHN J. DUDA		24H. ADDRESS 7922 Wise Ave. Dundalk, 21222			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2630		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2630	
M.E. CASE NO.		CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) PLASKIE Leo, N. SR.	
2. DATE AND HOUR OF DEATH		March 6, -1965 5:20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md B. COUNTY Balto.			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		DUNDALK			
D. STREET ADDRESS (If rural, give location)		1778 Stokesley Rd #22			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-3-03	9. AGE (In years lost birthday) 61	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Roland Park School		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Plaskie		14. MOTHER'S MAIDEN NAME Ellen Snodgrass	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) army WWI		16. SOCIAL SECURITY NO. 226-10-1950		17. INFORMANT ADDRESS 1778 Stokesley Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO Cardiac Arrest.		—	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Cor Pulmonale		5 yr.	
		(C) DUE TO Emphysema		5 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-4-1965 to 3/6-1965, that (I) (we) last saw the deceased alive on 3/6-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/6/65	
23C. PHYSICIAN'S NAME (Type) John B. STRAM		M.D. ADDRESS		Maryland Gen'l Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-10-1965		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn	
24D. LOCATION (City, town, or county) (State) Eastern Ave. Bal. Co. Dundalk, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 10 1965		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA, 7922 Wise Ave. Dundalk, 21222					

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Main body of handwritten text, consisting of several lines of cursive script that are difficult to decipher.

Handwritten text at the bottom of the page, including what appears to be a signature and possibly a date or reference number.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2631</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2631</b>	
M.E. CASE NO.		ISABELLA KRUSE			
1. NAME OF DECEASED (Type or Print)		KRUSE ISABELLA		2. DATE AND HOUR OF DEATH <b>3-5-65 10:10 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME and Hosp</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore - Dundalk</b>			
		D. STREET ADDRESS (If rural, give location) <b>7835 Wise Ave. 63-00</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>11-16-1900</b>	9. AGE (In years lost birthday) <b>64</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Webb</b>		14. MOTHER'S MAIDEN NAME <b>Anna Geiser</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Daughter, Virginia Kruse, 7835 Wise Ave. 21222</b>	
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Anterioderotic heart disease</b>		CAUSE OF DEATH (A) <b>Postmortem</b> DUE TO (B) <b>Anterioderotic heart disease</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2-20</b> 19 <b>65</b> to <b>3-5</b> 19 <b>65</b> , that (I) (we) lost saw the deceased alive on <b>3</b> 19 <b>65</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jose S. Maisog M.D.</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-5-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jose S. Maisog M.D.</b>		23D. ADDRESS <b>Church Home and Hosp</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Mar-9-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart of Jesus</b>	
24D. LOCATION (City, town, or county) (State) <b>German Hill Rd. Dundalk, Md. 21222</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Bailey, M.D.</b>	
25C. FUNERAL DIRECTOR <b>JOHN J. DUDA</b>		ADDRESS <b>7922 Wise Ave. 21222, Md.</b>			



1985-1986 2-2-86

11-16-86 11-16-86

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11-16-86 11-16-86

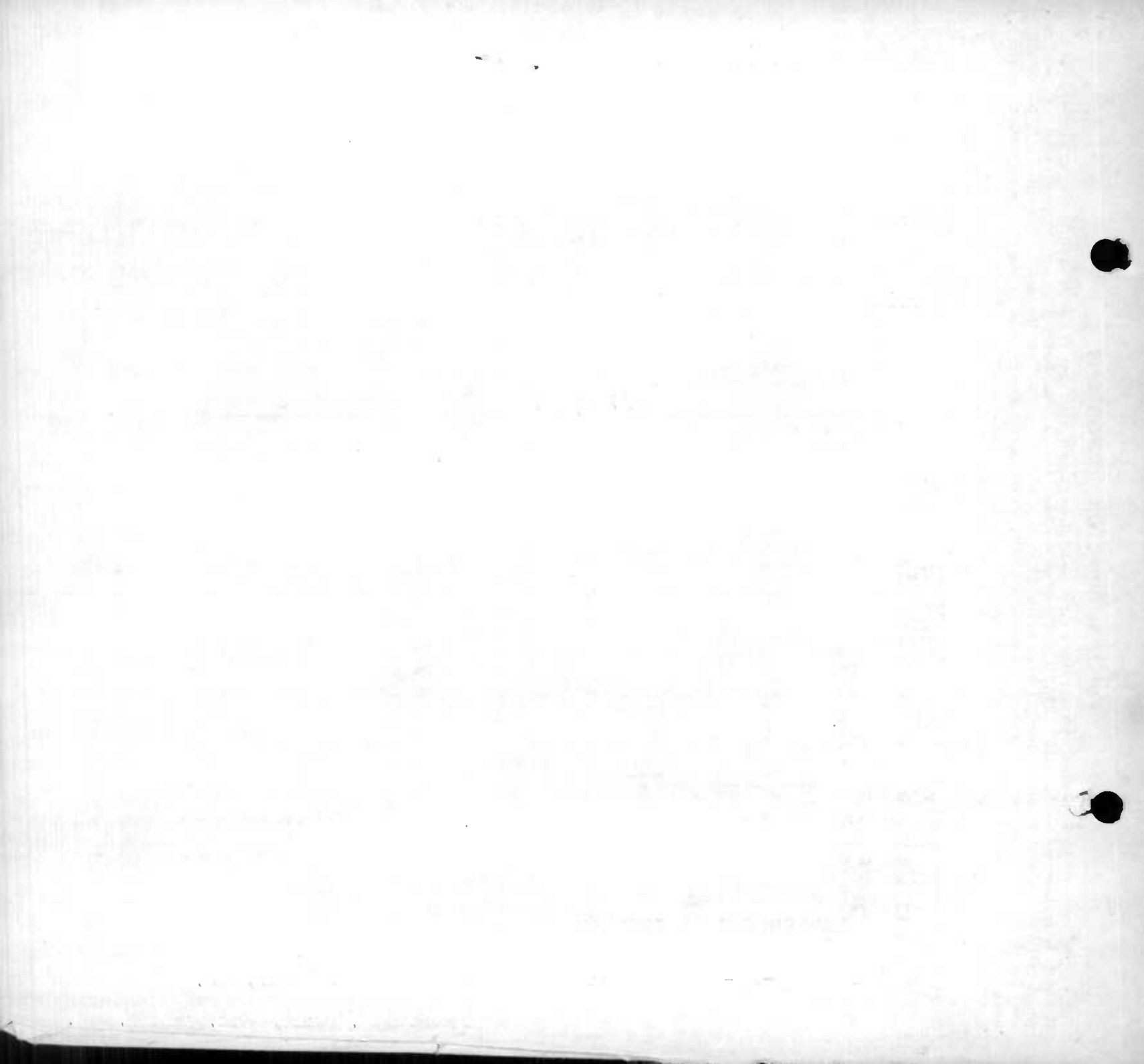
11-16-86 11-16-86

11-16-86 11-16-86

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

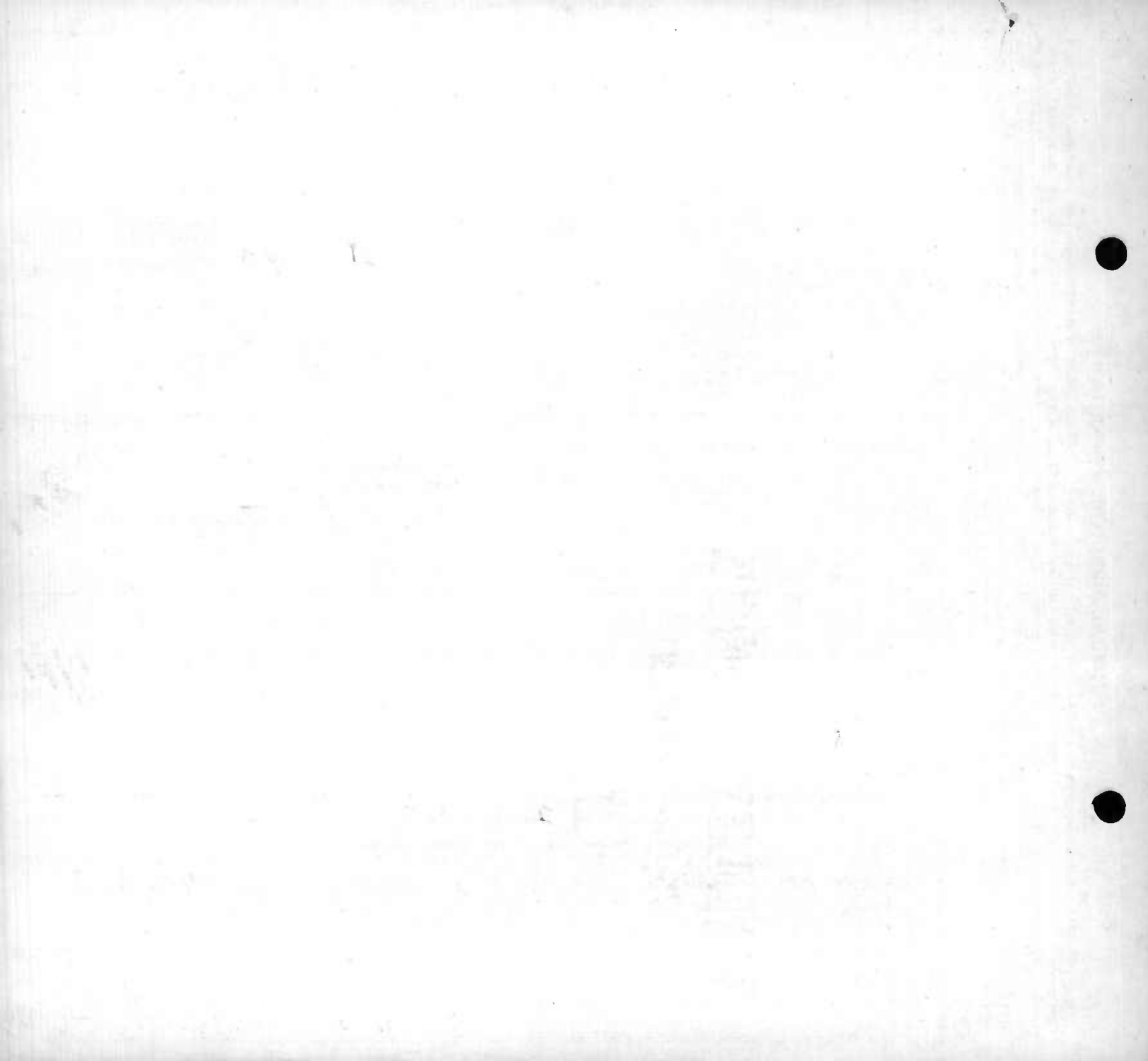
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2632</u>	
BIRTH NO. <u>65 2632</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <u>Charles Robert</u> (Type or Print) <del>Robert</del> <u>Smith</u>		2. DATE AND HOUR OF DEATH <u>3-9-65</u>   <u>2</u> <sup><u>30</u></sup> <u>PM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>27-12</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>6017 Sycamore Road</u>			
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>1-2-02</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charles W. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Margaret A. Erbe</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>216073314</u>		17. INFORMANT ADDRESS <u>char - Union Memorial Hosp.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Circulation, nutritional</u> <u>severe &amp; jaundice</u> <u>and acute</u> <u>chronic nephrosis</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>2-22</u> <u>1965</u> to <u>3-9</u> <u>1965</u> , that (2) (we) last saw the deceased alive on <u>3-9</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lawrence J. Lieberman</u> M.D.				23B. DATE SIGNED <u>3-9-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>LAWRENCE J. LIEBERMAN</u>				23D. ADDRESS <u>Union Memorial Hospital</u> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-13-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 10 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc., Balto., Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

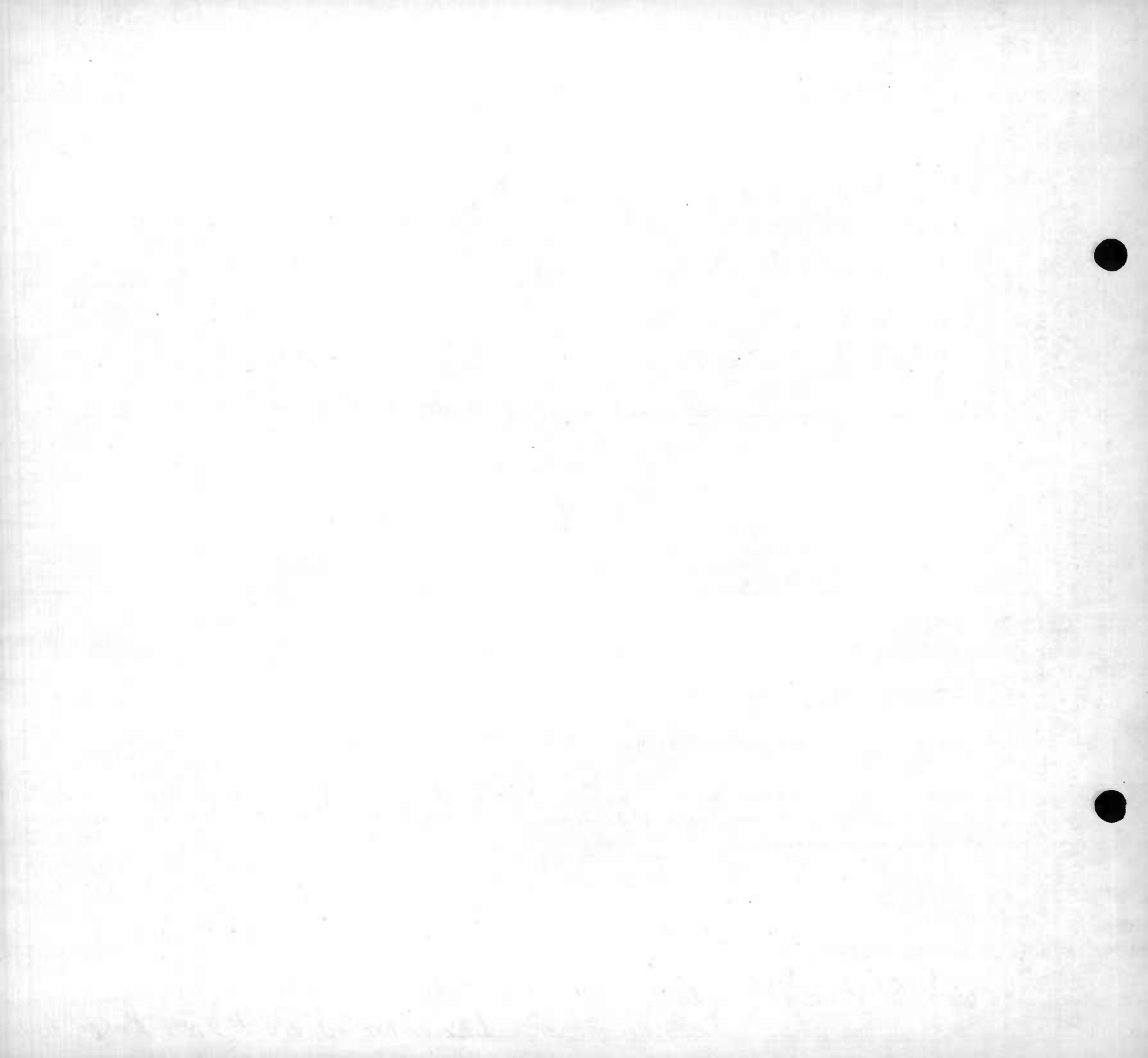
Baltimore City Health Department				Registered No. 65 2638	
BIRTH NO. 65 2638		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Ohlie Little</i>		2. DATE AND HOUR OF DEATH <i>March 4, 1965</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Hb Lutheran Hosp.</i>		A. STATE <i>Maryland</i> B. COUNTY <i>15-38</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>2915 Chelsea Terrace</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>Nov. 4, 1901</i>	9. AGE (In years last birthday) <i>43</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>unk</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Edward Smith</i>			
14. MOTHER'S MAIDEN NAME <i>Maggie Thompson</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cerebrovascular Accident - Hemorrhage</i> DUE TO (B) <i>Essential Hypertension</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Mar 1961</i> to <i>Mar 1965</i> , that (I) (we) last saw the deceased alive on <i>2-19-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <i>Ann H. Carby</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>9-4-65</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-9-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Carver Mem. Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Laureh, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 10 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>W. Wilson</i>			
25D. ADDRESS <i>1000 Brantley Ave.</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2633</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2633</b>	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Rex Roth, Verna Lee</b>				March 9, 1965 1:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-12</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND General Hospital</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
				D. STREET ADDRESS (If rural, give location) <b>6000 Bellona Ave (Edgewood Nursing Home)</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED.</b>	8. DATE OF BIRTH <b>10/3/97</b>	9. AGE (In years last birthday) <b>67</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>York penna.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Edward L. Zeone dec</b>		
14. MOTHER'S MAIDEN NAME <b>Mattie Blocker dec.</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>215-074415</b>			17. INFORMANT ADDRESS <b>MRS. JEAN R. Dumlet - 1228 Sheridan Ave</b>		
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular accident.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(Cerebral Hemorrhage).</b>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>3-12-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 6, 1965</b> to <b>March 9, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 9, 1965</b> and that in <b>(a)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(a)</b> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Yim, Pill Sun</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>March 9-1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Yim, Pill Sun</b> M.D.				23D. ADDRESS <b>Maryland General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>3-12-65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Morland Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Bailey, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>LEONARD J. RUCK INC. BALTO., Md.</b>	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 2634</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.2em;">65 2634</span> <b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">CAROLYN CHEW</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">1:40 AM - Mar. 9-1965</span> M.			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <span style="font-size: 1.2em;">UNIVERSITY</span> </div> <div>                         (If not in hospital or institution, give street address or location)                     </div> </div>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> <b>A. STATE</b>  <span style="font-size: 1.2em;">Md.</span> </div> <div> <b>B. COUNTY</b>  <span style="font-size: 1.2em;">Baltimore</span> </div> </div> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span> <b>D. STREET ADDRESS</b> (If rural, give location) <span style="font-size: 1.2em;">3431 GREENMOUNT Ave.</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">F</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">Oriental</span>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (specify) <span style="font-size: 1.2em;">Single</span>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">11-23-48</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">16</span>	<b>If Under 1 Yr.</b> Months: _____ Days: _____
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Student</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">[Blank]</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Hong Kong, China</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">US</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Donald Chew</span>			
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">LINA Leong</span>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)			
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">MR. DONALD CHEW,</span>		<b>ADDRESS</b> <span style="font-size: 1.2em;">SAME</span>	
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                          (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                          DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                     </div> <div> <b>(A) DUE TO</b>  <span style="font-size: 1.2em;">Meningococcia</span>   <b>(B) DUE TO</b>  <span style="font-size: 1.2em;">[Blank]</span>   <b>(C) DUE TO</b>  <span style="font-size: 1.2em;">[Blank]</span> </div> <div> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">[Blank]</span> </div> </div>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b> <span style="font-size: 1.2em;">S. L. E.</span>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">2</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">YES</span>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3/6/65</span> to <span style="font-size: 1.2em;">3/7/65</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3/7/65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Francine Camitto</span> M.D.				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3/7/65</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Francine Camitto</span> M.D.				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Univ. Hospital</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">BURIAL</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">3-10-65</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Dulaney Valley Mem.</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 10 1965</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">R. B. E. Staley, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">LEONARD J. RUCK, INC.</span>			
<b>ADDRESS</b> <span style="font-size: 1.2em;">BALTO., MD., 21214</span>		<b>VS 150-REV. 1/1/65</b>			

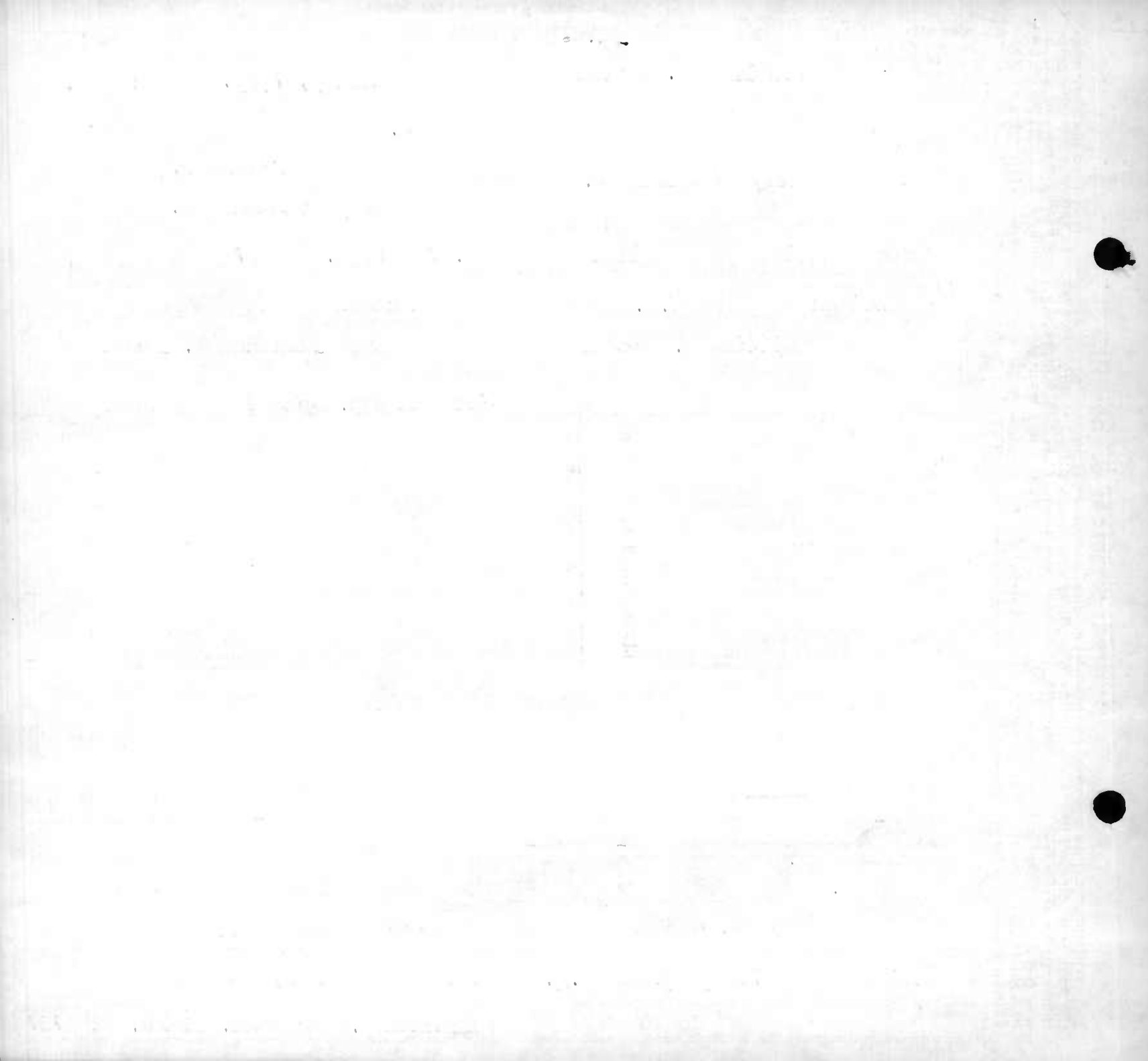


Certificate, to be approved by Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

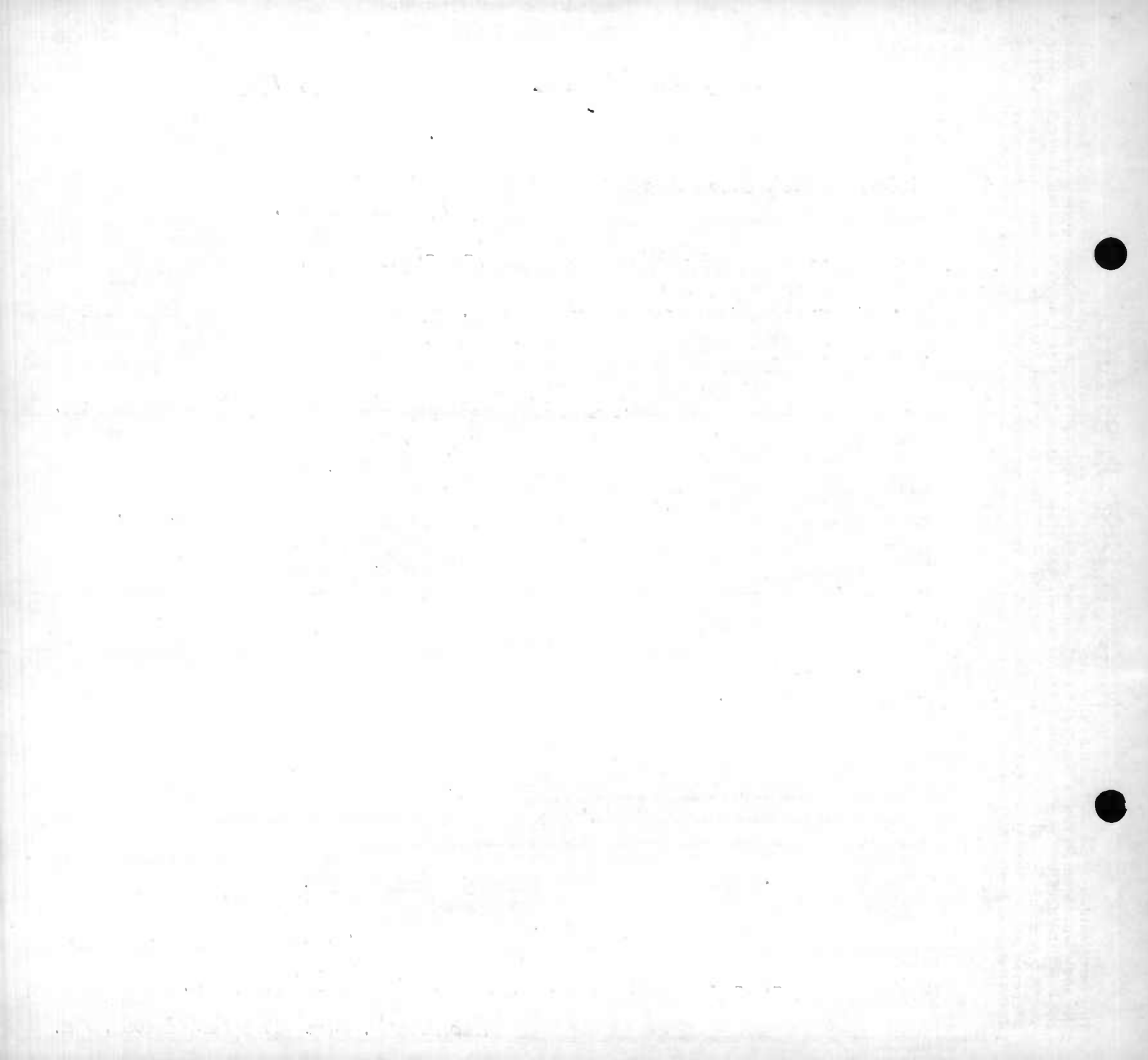
BIRTH NO. 65 2635				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2635	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Irvin R. Sparks				2. DATE AND HOUR OF DEATH March 7, 1965. 1:00 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2807 Overland Rd. AVE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #14 D. STREET ADDRESS (If rural, give location) 2807 Overland Rd. AVE			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Aug. 10, 1893.	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Sparks				14. MOTHER'S MAIDEN NAME Florence M. Fowble			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. M.D.		17. INFORMANT Miss Clara M. Sparks		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Acute myocardial failure Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH 15 min. 10 yrs.	
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 22, 1965 to March 7, 1965, that (I) (we) last saw the deceased alive on January 22, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Lloyd E. Saylor				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Mar. 8, 1965	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor				23D. ADDRESS M.D. 3902 Greenmount Ave., Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/10/65		24C. NAME OF CEMETERY or CREMATORY Grace M.E. Cemetery		24D. LOCATION (City, town, or county) (State) Upperco, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 10 1965		25B. NAME OF REGISTRAR R. E. Saylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md		ADDRESS 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2636		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 65 2636	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>Albert Ernest Kimmel</i>		
2. DATE AND HOUR OF DEATH <i>March 9, 1965</i>			M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2603</i>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			D. STREET ADDRESS (If rural, give location) <i>3319 Kenyon Ave.</i>		
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>4-20-1895</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Bethlehem Shipyard Employee</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Andrea Kimmel</i>			14. MOTHER'S MAIDEN NAME <i>Marie Marsch</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>215055363</i>		17. INFORMANT <i>Mrs Sophia Young</i> ADDRESS <i>3902 Woodlea Ave.</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>Coronary Occlusion</i> DUE TO (B) <i>Arteriosclerosis</i> DUE TO (C) <i>Thrombophlebitis Left arm</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>Indefinite</i> <i>3 wks.</i>
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1947</i> to <i>Mar 9</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Mar 8</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nathaniel M Beck M.D.</i> M.D. Attending <input checked="" type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Staff <input type="checkbox"/>			23B. DATE SIGNED <i>Mar 10-65</i>		
23C. PHYSICIAN'S NAME (Type) <i>Nathaniel M Beck M.D.</i>			23D. ADDRESS <i>2818 St Paul St Bq Ht #18 Md.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>	24B. DATE <i>3-12-65</i>	24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 10 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Stalks, M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i> ADDRESS <i>Baltimore, Md.</i>	

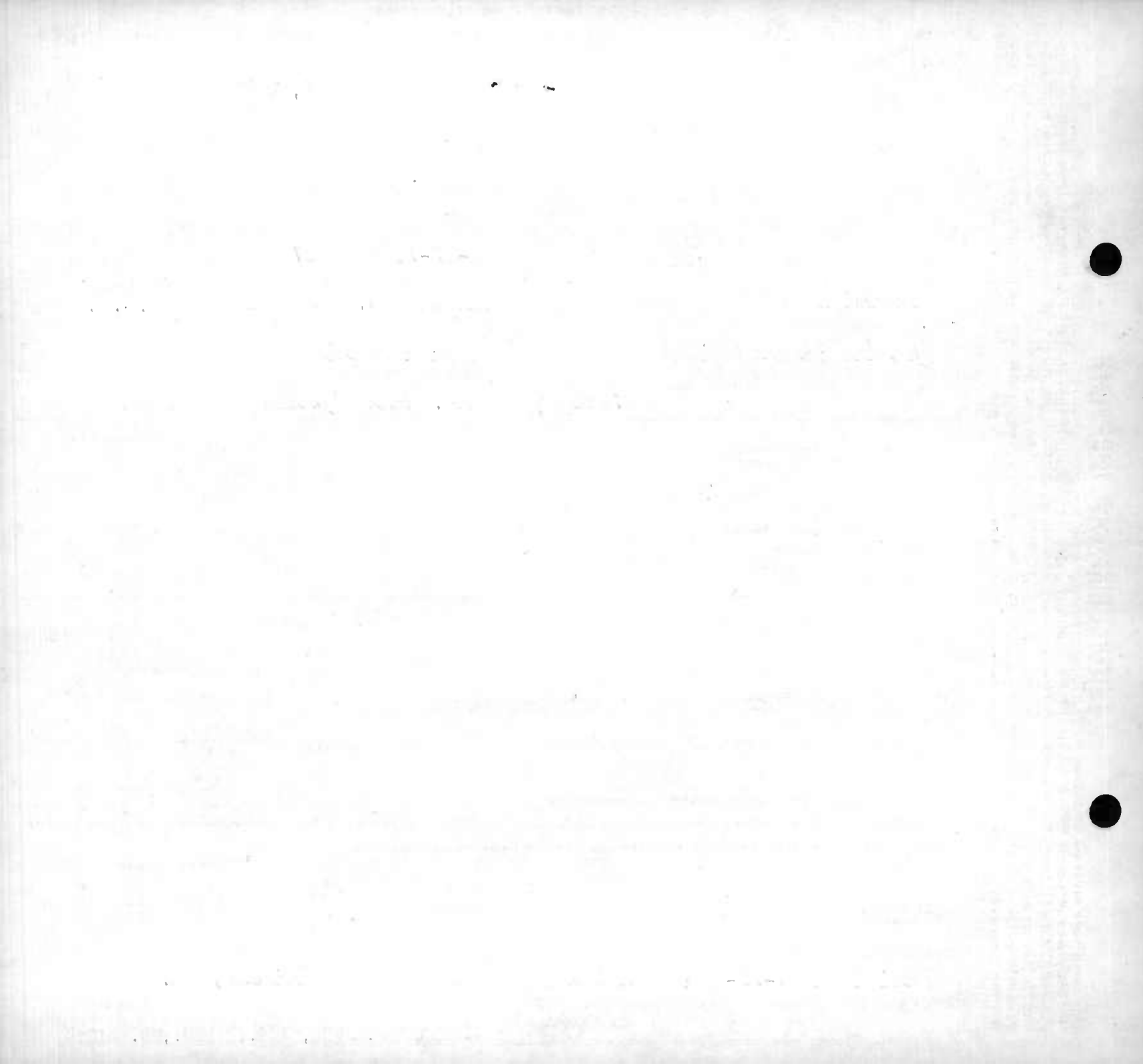


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2637		CERTIFICATE OF DEATH		Registered No. 65 2637	
1. NAME OF DECEASED (Type or Print) SEBA ELIZABETH KORNMANN				2. DATE AND HOUR OF DEATH MARCH 8, 1965 4:30 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2601 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 4810 ANNTANA AVENUE					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6-21-1883	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles Bernard Wight				14. MOTHER'S MAIDEN NAME Seba Pettit					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216283797		17. INFORMANT Mrs. Harry Correa		ADDRESS Same		
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Arteriosclerotic Heart Disease DUE TO (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Senile Pulmonary Emphysema					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4-23-1963 to 2-11-1965, that (I) (we) last saw the deceased alive on 2-11-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Juri Hinnno				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-9-65			
23C. PHYSICIAN'S NAME (Type) JURI HINNO				23D. ADDRESS 502 2 Frankford apt Baltimore 6 Md					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-11-65		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 10 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214		ADDRESS			





65 2639

BALTIMORE CITY HEALTH DEPARTMENT

65 2639

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

THOMAS HENDERSON

2. DATE AND HOUR PRONOUNCED DEAD

3-8-65

7:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2037 Orleans Street 21231

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

M

8. DATE OF BIRTH

Nov 2-1901

9. AGE (In years  
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Henderson N. Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

James Henderson

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Carmie Henderson

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

P. W. Rieckert

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

3-8-65

EXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3-13-1965

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

Brooklyn, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 10 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

E. O. Wilson

ADDRESS

1600 Brantley Ave.

VALLEY

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OF

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OF

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1800

1800

1  
360

65 2640

BALTIMORE CITY HEALTH DEPARTMENT

65 2640

BIRTH NO. 64-0182

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EDWARD JETTER

2. DATE AND HOUR PRONOUNCED DEAD

3-7-65

1:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

607 W. Mulberry Street 21201

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Baby

8. DATE OF BIRTH

March 9-1964

9. AGE (In years last birthday)

1 yr.

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James S. Jetters

14. MOTHER'S MAIDEN NAME

Mary Lee Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mary Lee Murray

ADDRESS

Same

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Otitis media

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

3-8-65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

3-12-1965

23C. NAME OF CEMETERY or CREMATORY

Int Calvary Ch

23D. LOCATION (City, town, or county)

Brooklyn

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

MAR 10 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Choy Wilson 1001 Broadway

ADDRESS

WALTER FEENE

PAGE 2

NEW

L-500

65 2641

BALTIMORE CITY HEALTH DEPARTMENT

65 2641

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ALEXANDER LANEY 2. DATE AND HOUR PRONOUNCED DEAD 3/9/65 1:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 400 E. Federal St. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 400 E. Federal St.

5. SEX male 6. RACE colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 8. DATE OF BIRTH June 12, 1894 9. AGE (In years last birthday) 68 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Helper 11. BIRTHPLACE (State or foreign country) N. Carolina 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 215-01-0772 17. INFORMANT ADDRESS

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH (A) Shotgun wound of head DUE TO (B) DUE TO (C)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) no 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 400 E. Federal St.

21D. TIME OF INJURY (APPROX.) 3 9 65 12:00 m. 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR? shotgun wound of mouth

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) W.H. Spitz, M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

DATE SIGNED 3/9/65

23A. BURIAL CREMATION, REMOVAL (Specify) 23B. DATE 3-12-65 23C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. 23D. LOCATION (City, town, or county) (State) Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT. MAR 10 1965 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR 24D. ADDRESS

VS 151-REV. 1/1/65

WALLACE BOWEN

1900

1900



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

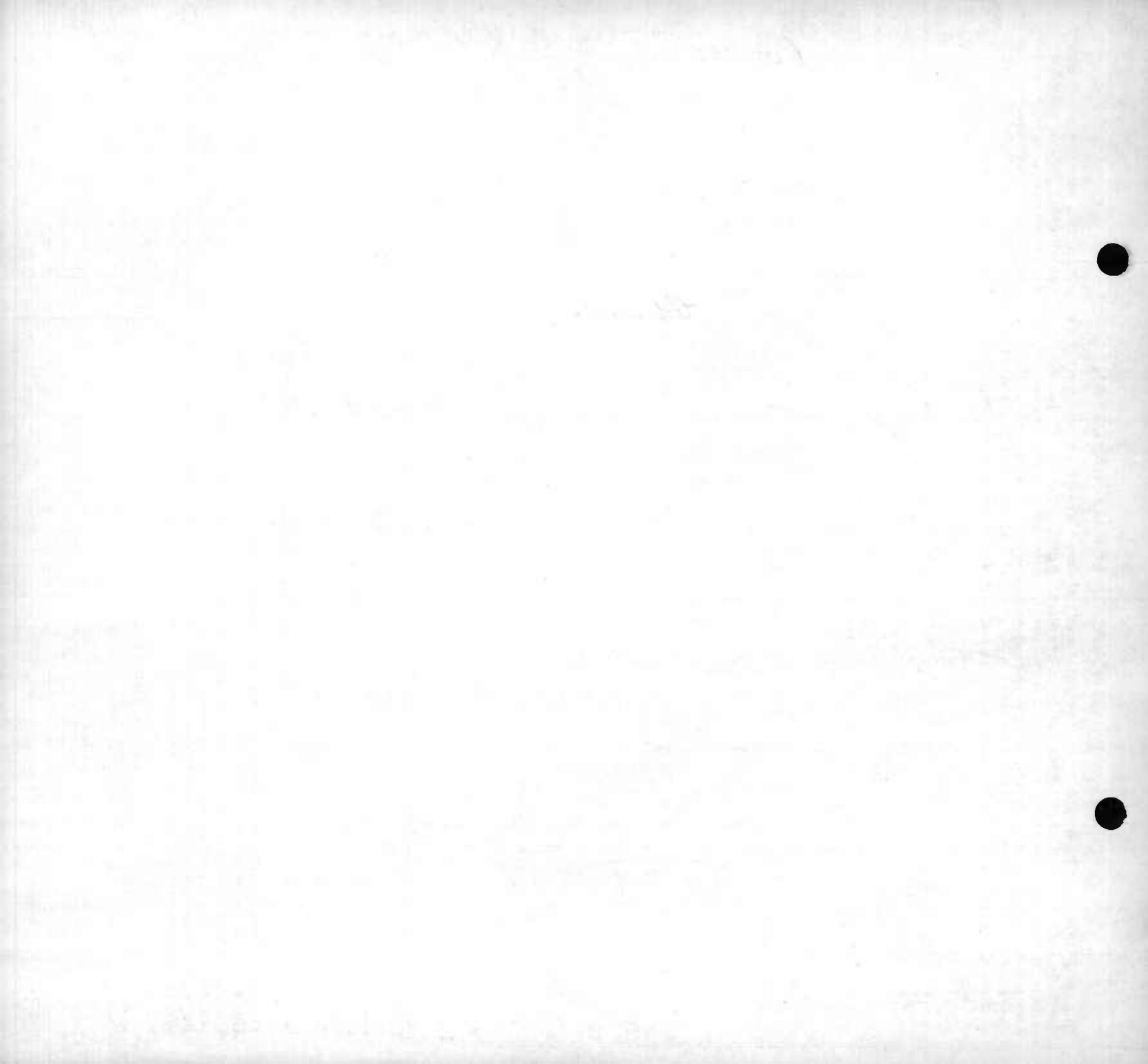
BIRTH NO. 65 2642				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2642	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SMITH, BERTHA E.				2. DATE AND HOUR OF DEATH March, 7, 1965 9:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MD		B. COUNTY 19-03	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21223			
				D. STREET ADDRESS (If rural, give location) 345 S. Gilmore St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 11/2/76	9. AGE (In years last birthday) 88 40	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN M. BYRLEY				14. MOTHER'S MAIDEN NAME ELIZABETH ARNSPARGER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT BEULAH PEARL S/A		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) coronary - ASCVD -			
ANTECEDENT CAUSES				(B) autopsy pending			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Superior mesenteric thrombosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 3/6/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrenous small bowel		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 3-1-65 to 3-7-65, that (X) (we) last saw the deceased alive on 3-7-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Francesco M. Sandiford M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/7/65	
23C. PHYSICIAN'S NAME (Type) FRANCESCO M. SANDIFORD				23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/11/65		24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Cem. A. A. Co.		24D. LOCATION (City, town, or county) (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 11 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Walkers Funeral Home - Pratt & Strickland		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

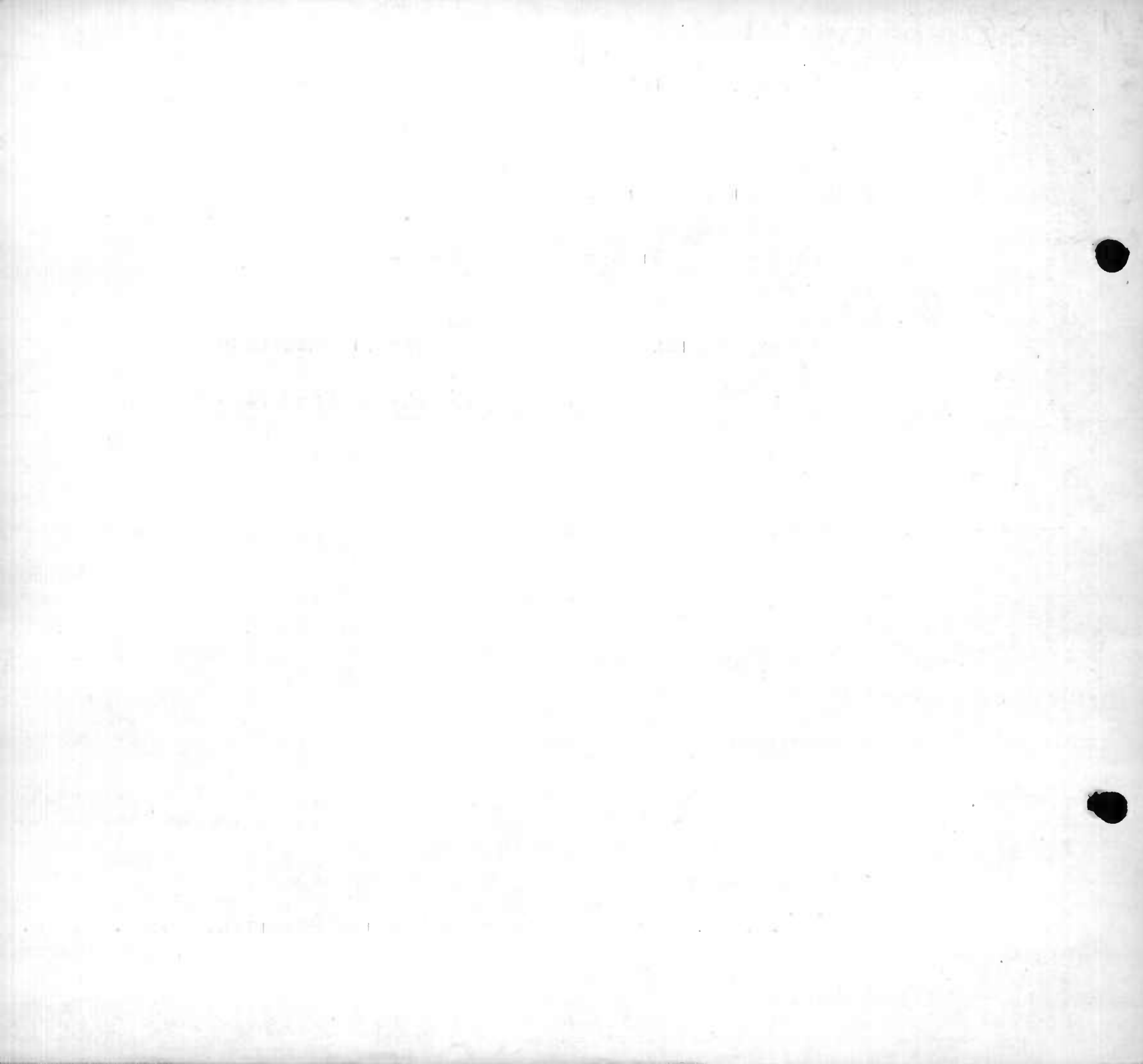
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2643	
BIRTH NO. 65 2643		CERTIFICATE OF DEATH			
M.E. CASE NO. (Dukes)		1. NAME OF DECEASED (Type or Print) Dutkevich Peter Alphonsus		2. DATE AND HOUR OF DEATH 9 March 1965 12:45 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital		A. STATE Maryland B. COUNTY Baltimore 1			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 1			
		D. STREET ADDRESS (If rural, give location) 24 Parkin St. - Zone (1)			
5. SEX Male	6. RACE Cave.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-14-06	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Church Sexton		10B. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Vincent Dutkevich		14. MOTHER'S MAIDEN NAME Agatha Zardesky	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-09-2350		17. INFORMANT Mrs. Theresa Dutkevich (Sister) ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Septicemia (B) Intracranial bleeding (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from March 1 1965 to March 9 1965, that (we) last saw the deceased alive on March 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward J. Ruley, M.D.		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9 March 1965	
23C. PHYSICIAN'S NAME (Type) Edward J. Ruley		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/12/65		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION (City, town, or county) Baltimore		(State) Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 11 1965		25B. NAME OF REGISTRAR Robert E. Tolson		25C. FUNERAL DIRECTOR J. J. Gorman	
				ADDRESS 901 Halling St	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>65 2644</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2644</b>	
M.E. CASE NO. <b>65 2644</b>			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>LAVERNE MCNEILL</b>			2. DATE AND HOUR OF DEATH <b>3-8-65 10:AM</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>8-07</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 13</b> D. STREET ADDRESS (If rural, give location) <b>1604 E. PRESTON STREET</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>12-25-32</b>	9. AGE (In years last birthday) <b>32</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BA9. Co.</b>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>HARVEY MCNEILL</b>			14. MOTHER'S MAIDEN NAME <b>BEDELIA MCCALLUM</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 7/11/58-9/12/58</b>			16. SOCIAL SECURITY NO. <b>240-42-2791</b>		17. INFORMANT ADDRESS <b>BEDELIA MCNEIL 1604 E. PRESTON ST</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>493X4 322.1</b> <b>Pneumococcal Pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Alcoholism</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3.6</b> 19 <b>65</b> to <b>3.8</b> 19 <b>65</b> , that (I) <del>was</del> lost saw the deceased alive on <b>3.8</b> 10 <b>00</b> 19 <b>65</b> and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>W Maxson</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3.8. 65</b>
23C. PHYSICIAN'S NAME (Type) <b>M.T. MAXSON</b>			23D. ADDRESS M.D. <b>JOHNS HOPKINS HOSPITAL, BALTO. 5, MD.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>3/12/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Balto. National</b>		24D. LOCATION (City, town, or county) (State) <b>5501 Frederick Ave</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 11 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Staley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Joseph L. Locks 1304 N. Central Ave</b>	

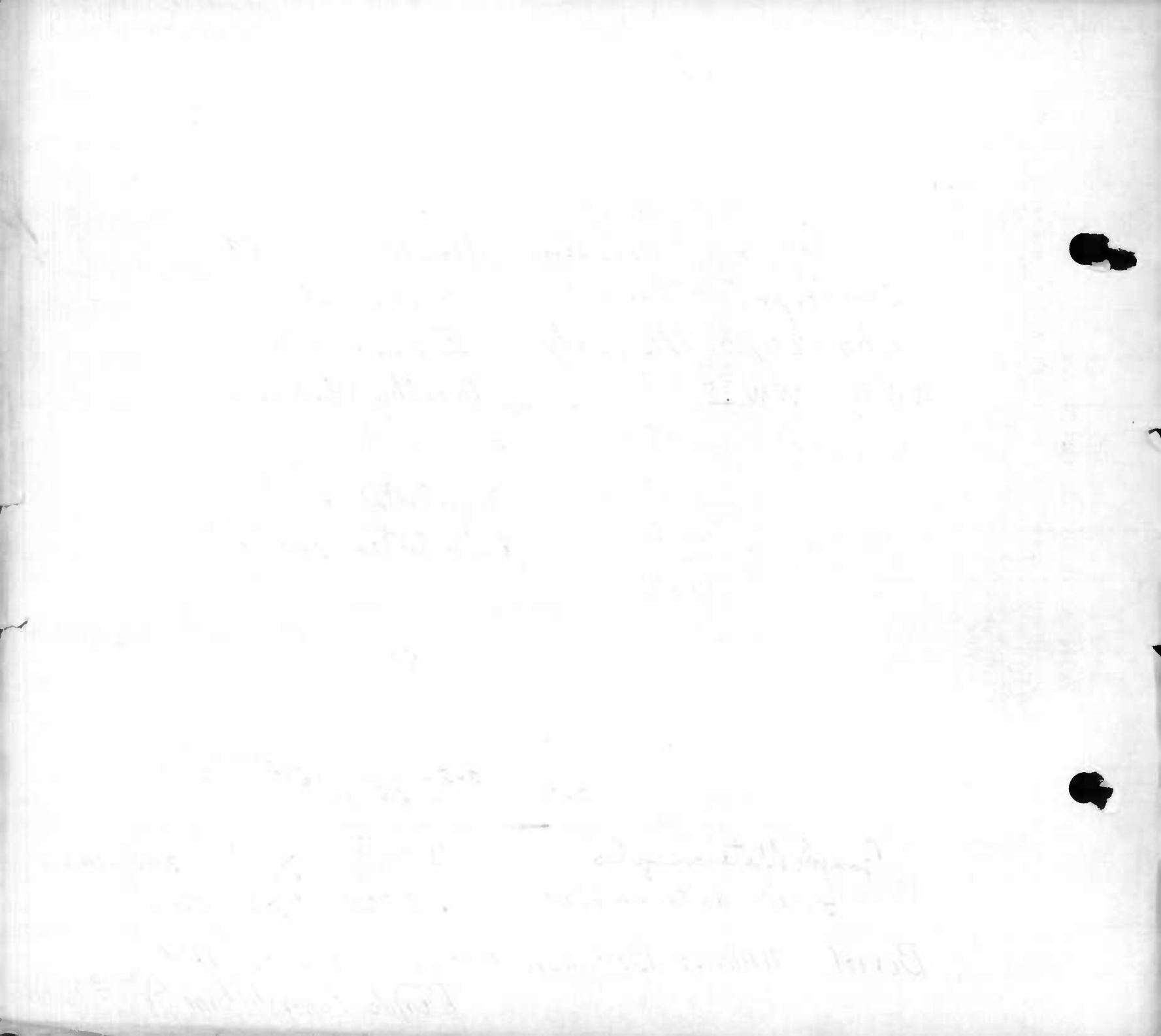


# FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				Registered No. 65 2645	
BIRTH NO. 65 2645		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Earl V. McCarty</i>		2. DATE AND HOUR OF DEATH <i>3-8-65 10:50 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>4-01</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>10 E Pratt St.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>DIVORCED</i>	8. DATE OF BIRTH <i>MAR 15, 1910</i>	9. AGE (In years lost birthday) <i>54</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Taxi cab</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>John Joseph McCarty</i>		14. MOTHER'S MAIDEN NAME <i>Emma Ulrich</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>WW II WW II</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Dorothy Stahler 6003 Falls Rd</i>	
18. <i>260X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>overwhelming pneumonia</i> DUE TO (B) <i>Diabetic acidosis</i> DUE TO (C) <i>Diabetes mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-8-1965</i> to <i>3-8-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joseph Notarangelo</i>		M.D. <i>2650</i> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3-8-1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOSEPH NOTARANGELO</i>		23D. ADDRESS <i>MERCY HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11 Mar 65</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore National</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 11 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Burke Funeral Home 3631 Falls Rd</i>	





# FUNERAL DIRECTOR: IMPORTANT

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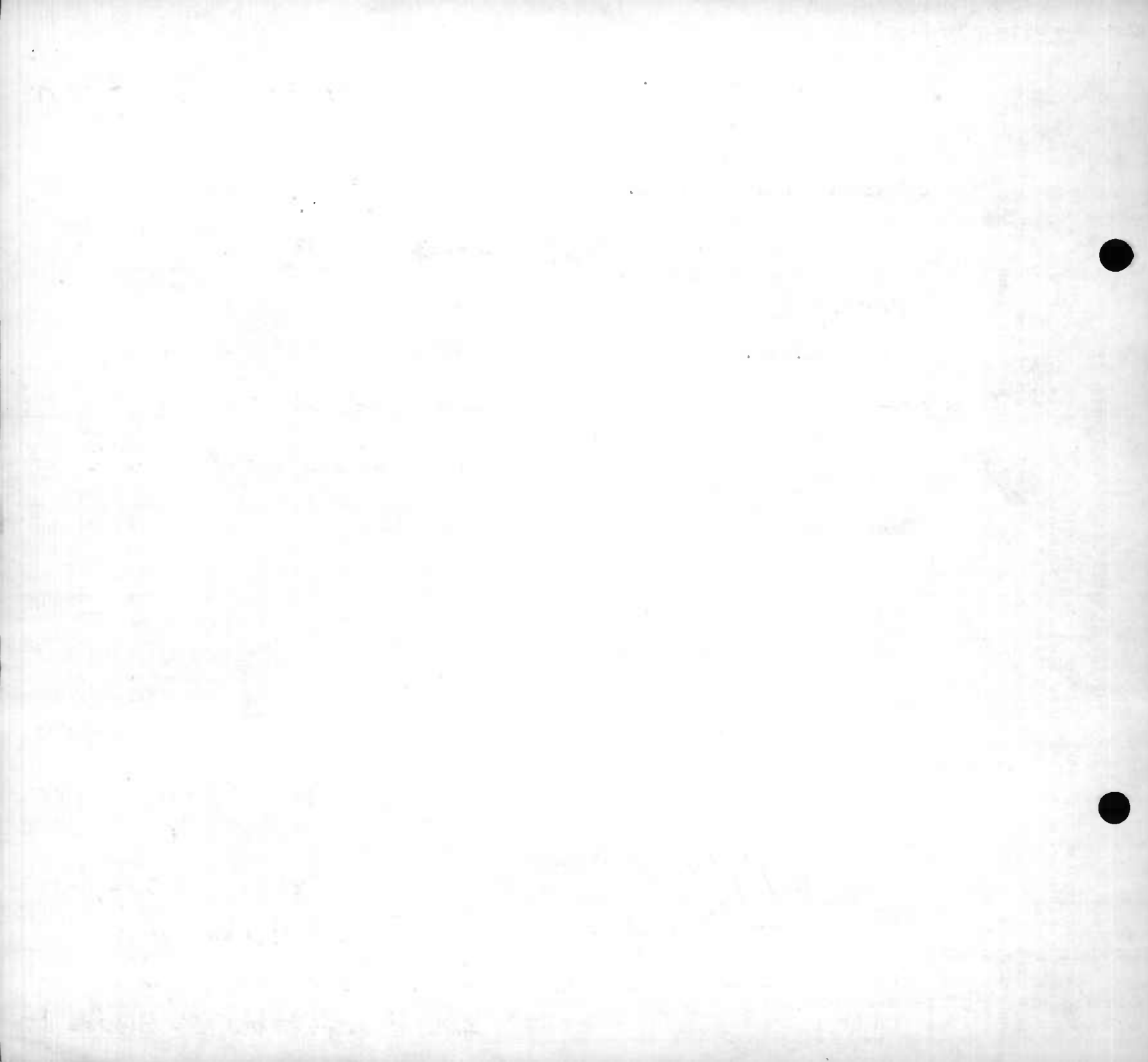
BIRTH NO. 65 2646				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2646	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>INEZ WEBB</b>				2. DATE AND HOUR OF DEATH <b>March 8, 1965</b> <b>5:00 a. m.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3532 Roland Avenue</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>13-06</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3532 Roland Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 31, 1878</b>		9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Christian Stone</b>				14. MOTHER'S MAIDEN NAME <b>Thirza Ellen Rice</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Joseph M. Webb, 3532 Roland Avenue, Balto. Md.</b>			
18. <b>44281</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Cardio-renal Vascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Cardio-renal Vascular Disease</b> DUE TO (B) <b>-</b> DUE TO (C) <b>-</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 mos</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1961</b> to <b>March 8, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 8, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>T.N. Wilson</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED <b>March 9, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>T.N. Wilson</b>		23D. ADDRESS <b>617 W. 40th Street</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11 Mar 65</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 11 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Stasch</b>		25C. FUNERAL DIRECTOR <b>George Funeral Home 3631 Falls Rd Balto. Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <span style="font-size: 1.2em;">65 2647</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 2647</span>		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">GEORGE LOREK.</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3/9/-65</span> <span style="float: right;">2:36 <sup>P</sup>M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">33 JOHNS HOPKINS HOSPITAL.</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">6-01</span>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE, 24</span>		
			D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">108 CURLEY ST.</span>		
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">LUTHERAN MAR.</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">2-21-13</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">52</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">MACHINIST</span>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND.</span>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <span style="font-size: 1.2em;">JOHN LOREK.</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">ANNA</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">WW-2</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">246-03-7780</span>	17. INFORMANT ADDRESS <span style="font-size: 1.2em;">EDNA LOREK 108 N. CURLEY ST.</span>		
18. <span style="font-size: 1.2em;">420.11</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Acute myocardial infarct</span> DUE TO (B) DUE TO (C)  INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">3 1/2 hrs</span>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">No</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes.</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <span style="font-size: 1.2em;">No</span>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <span style="font-size: 1.2em;">---</span>		21E. INJURY OCCURRED While At <input type="checkbox"/> Home Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3/8</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">3/9</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3/9</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">J. P. Kolko</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">3/9/-65</span>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<span style="font-size: 1.2em;">J. P. Kolko</span>		<span style="font-size: 1.2em;">Johns Hopkins Hosp.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">3-12-65</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">BOLTON NATL. CEMETERY</span>	
				24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE MD.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 11 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Talley, M.D.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Bodabrowski 2414 E. BALTIMORE ST.</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

65 2648

BIRTH NO. 65 2648

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Wiechert, Amelia

2. DATE AND HOUR OF DEATH

3-8-1965 7.35p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland 1-02

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

616 S. Curley St

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4-5-92

9. AGE (In years last birthday)

72

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

No

10B. KIND OF BUSINESS OR INDUSTRY

No

11. BIRTHPLACE (State or foreign country)

Spain

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Navarro

14. MOTHER'S MAIDEN NAME

Catherine Carthea

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Husband, Mr. Frank Wiechert, # 4,a,b,c,d.

ADDRESS

18. 420.11

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

Coronary Insufficiency  
(Acute Myocardial Infarction)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work

Not While At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 8, 1965 to March 8, 1965, that (I) (we) last saw the deceased alive on March 8, 1965 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Yim, Pill Sun

M.D.

Attending Phys.

Med. Director

Staff Phys.

23B. DATE SIGNED

March 8-1965

23C. PHYSICIAN'S NAME (Type)

Yim, Pill Sun

M.D.

23D. ADDRESS

Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

March 12-1965

24C. NAME of CEMETERY or CREMATORY

Oak Lawn

24D. LOCATION

(City, town, or county)

(State)

Eastern Ave. Balto. Co. Md. 21222

25A. DATE REC'D BY HEALTH DEPT.

MAR 11 1965

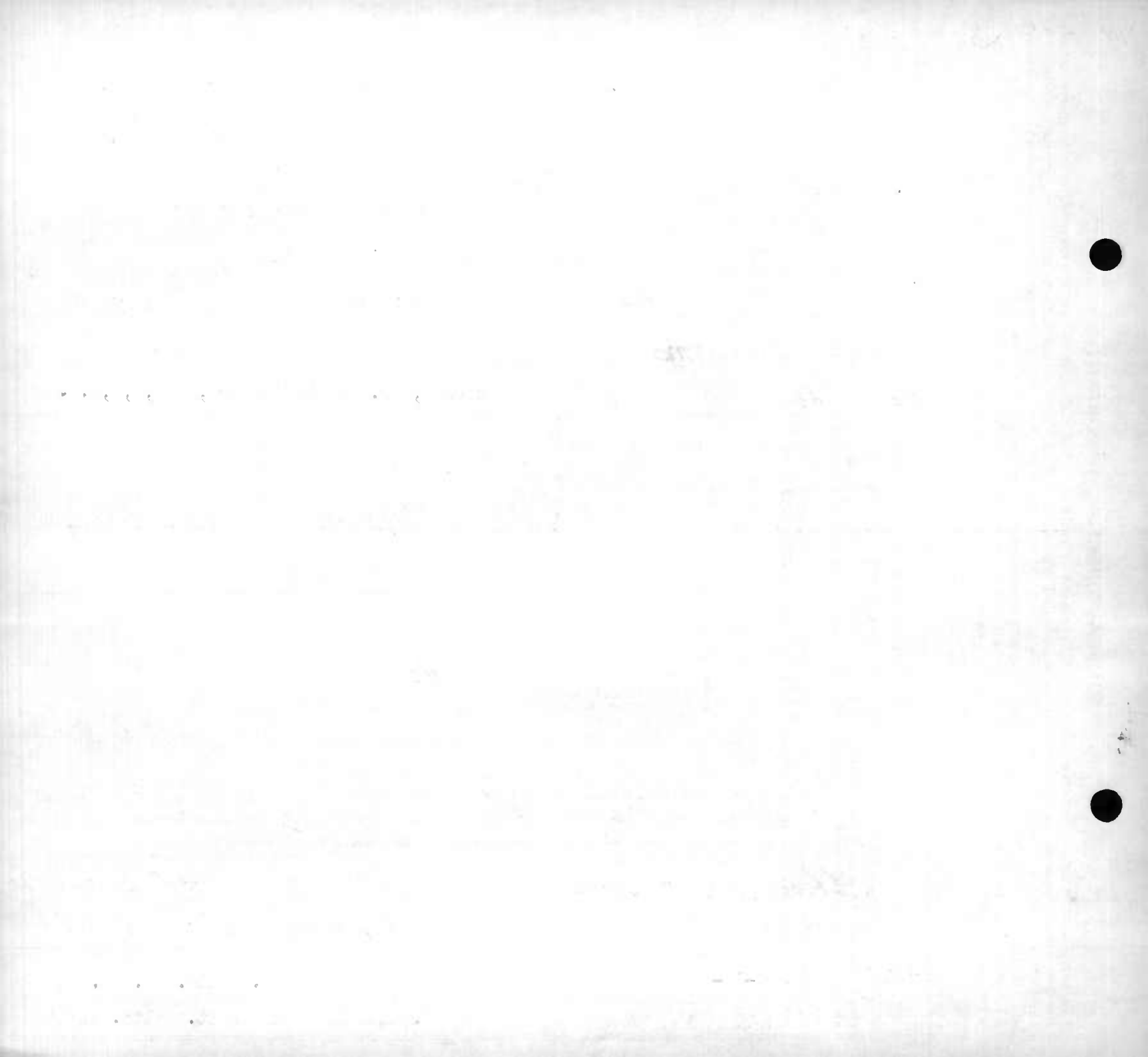
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

JOHN J. DUDA 2829 Hudson St. Balto. 21224

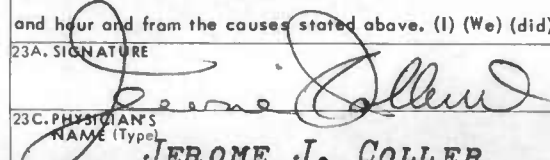
ADDRESS





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

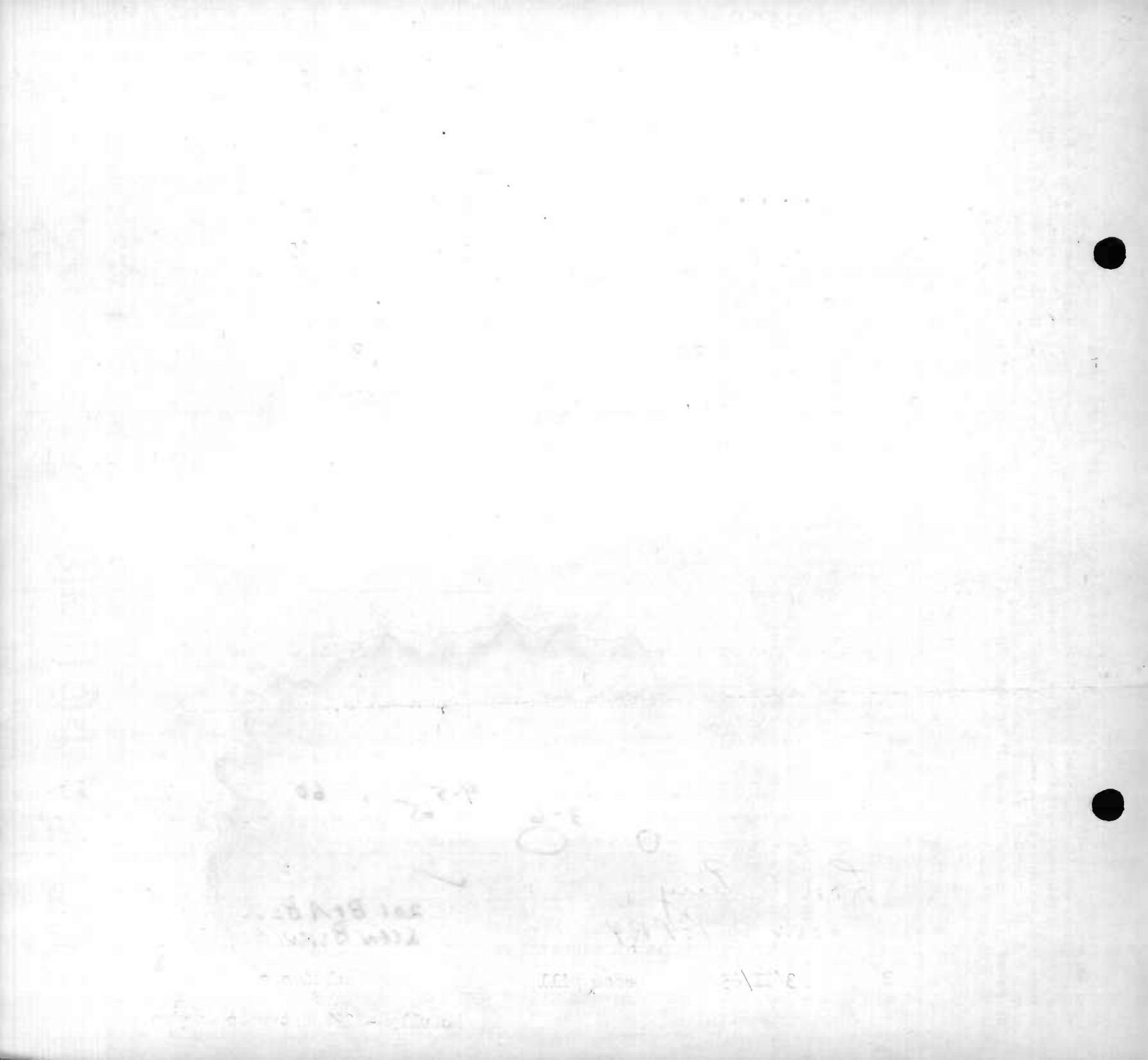
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 2649</b>	
BIRTH NO. <b>65 2649</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MRS. ALICE G. HORLANDER</b>		2. DATE AND HOUR OF DEATH <b>MARCH 9, 1965</b>	
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1101</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>104 E. MADISON STREET</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>104 E. MADISON STREET</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4/8/89</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED HOSERY MENDER, SIMON CO.</b>		11. BIRTHPLACE (State or foreign country) <b>PHILADELPHIA, PA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>HARRY GEISEKING</b>		14. MOTHER'S MAIDEN NAME <b>CLARA MOYER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MR. F. L. HORLANDER 104 E. MADISON ST</b>	
18. <b>42011</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY OCCLUSION</b>		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>A.S.C.V.D.</b>			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-9-65</b> to <b>3-9-65</b> , that (I) (we) last saw the deceased alive on <b>3-9-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  JEROME J. COLLIER				23B. DATE SIGNED <b>3/9/65</b>	
23C. PHYSICIAN'S NAME (Type) M.D.		23D. ADDRESS M.D. <b>2217 South Rd Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>3/11/65</b>		24C. NAME of CEMETERY or CREMATORY <b>GREENMOUNT CEMETERY</b>	
24D. LOCATION (City, town, or county) <b>BALTIMORE, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 11 1965</b>			
25B. NAME OF REGISTRAR <b>R. B. B. Staley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H. W. MEARS &amp; SON 805 N. CALVERT ST</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 2em;">65 2650</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 2em;">65 2650</span>	
M.E. CASE NO.				Certificate of Death	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">SARA C. STICKELS</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3/7/65 7:18 P.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">S.B.G.H.</span>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">Glen Burnie</span>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Glen Burnie</span>	
				D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">III6 McHenry Drive</span>	
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">M</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">5/3/99</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">65</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">None</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Md.</span>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <span style="font-size: 1.2em;">Unknown</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Unknown</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Family - Same</span>
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 45%;"> <p><b>CAUSE OF DEATH</b></p> <p>(A) <span style="font-size: 1.2em;">CORONARY THROMBOSIS</span> DUE TO</p> <p>(B) <span style="font-size: 1.2em;">CORONARY ATHEROSCLEROSIS</span> DUE TO</p> <p>(C) _____</p> </div> <div style="width: 10%;"> <p><b>INTERVAL BETWEEN ONSET AND DEATH</b></p> <p><span style="font-size: 1.2em;">1 HR.</span></p> <p><span style="font-size: 1.2em;">4 YRS.</span></p> </div> </div>					
<p style="text-align: center;"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">9-5</span> 19 <span style="font-size: 1.2em;">60</span> to <span style="font-size: 1.2em;">3-7</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3-6</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Leon C. Perry</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">3-9-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">LEON C. PERRY</span>				23D. ADDRESS <span style="font-size: 1.2em;">201 B &amp; A Blvd, NW. Glen Burnie, MD</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">B</span>		24B. DATE <span style="font-size: 1.2em;">3/11/65</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Cedar Hill</span>	
24D. LOCATION <span style="font-size: 1.2em;">Baltimore</span>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 11 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">L. E. S. S. S. S.</span>		25C. FUNERAL DIRECTOR, ADDRESS <span style="font-size: 1.2em;">McCully - 237 Patapsco Avenue</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2651				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2651	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DOLINOWSKI, HELEN M.				2. DATE AND HOUR OF DEATH March 7, 1965 5:55 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - 21218 D. STREET ADDRESS (If rural, give location) 1773 Homestead Street -			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 4-21-15	9. AGE (In years lost birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Staudemeyer				14. MOTHER'S MAIDEN NAME Mary Condell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-20-7798		17. INFORMANT ADDRESS Andrew J. Dolinowski 1773 Homestead St. #18			
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Hypertensive heart disease with congestive Heart Failure DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 6, 19 65 to March 7, 19 65, and that (I) (we) lost saw the deceased alive on March 7, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Rostom D. Rivera M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED March 7, 1965	
23C. PHYSICIAN'S NAME (Type) Rostom D. Rivera M.D. M.D.				23D. ADDRESS 11400 N. Caroline Street- 21213			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-10-65		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) 6515 Boston Street Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 11 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Charles S. Seiler Balto., Md. 21224			

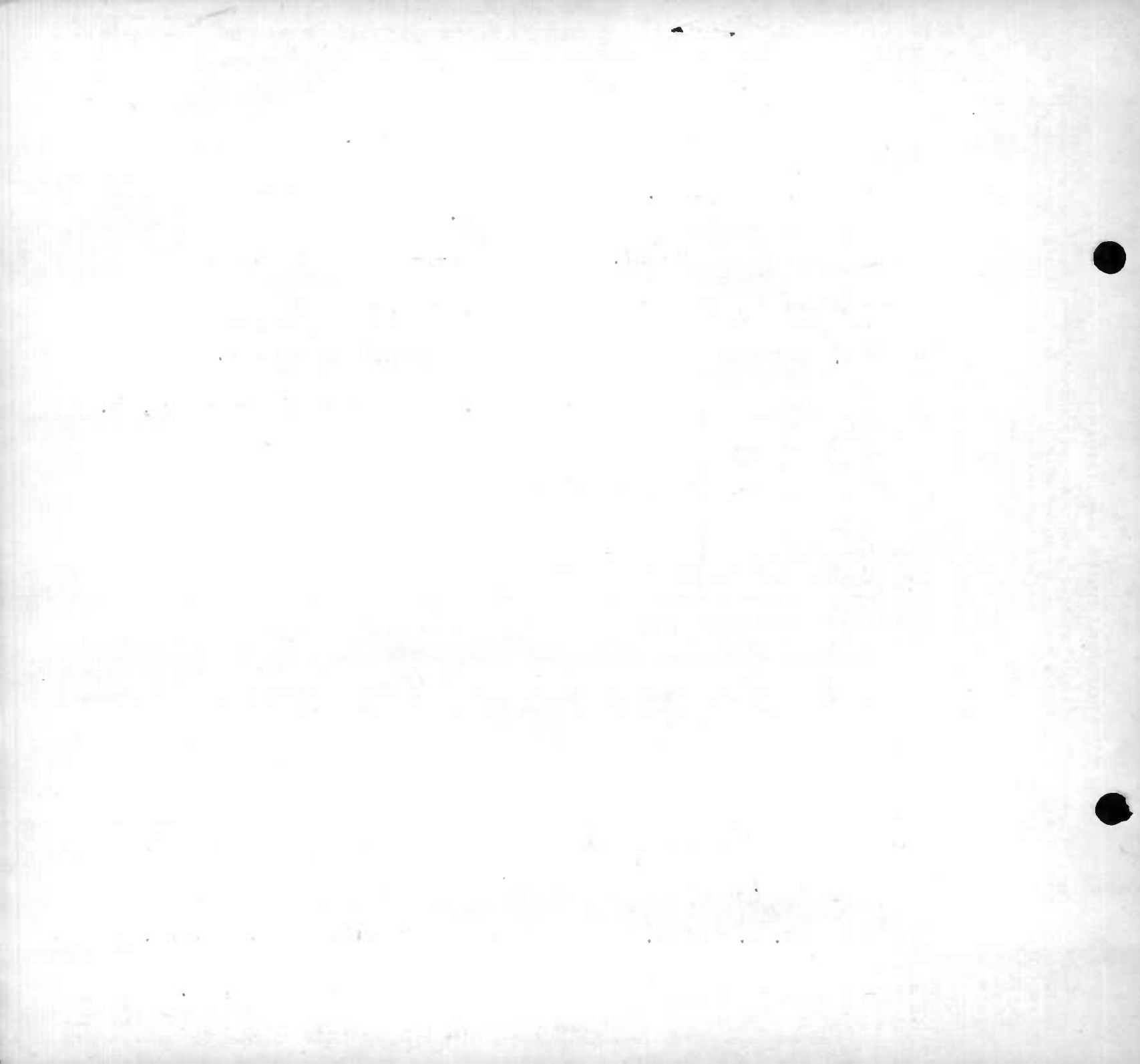


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2652				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2652	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				BABY GIRL HUNSBERGER		March 10, 1965 2:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
JOHNS HOPKINS HOSPITAL.				PENNA.		V-335	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				MERCERSBURG			
				D. STREET ADDRESS (If rural, give location)			
				RT. 2			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FEMALE	WHITE	INFANT.	3-5-65	5 DAYS	Never worked	Baltimore, Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HENRY C. HUNSBERGER				MARTHA GROSSNICKLE.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		None		Mr. Henry Hunsberger Mercersburg, Pa.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) Acute respiratory acidosis & cardiac arrest		36 hours	
ANTECEDENT CAUSES				(B) Prematurity		Since birth	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II				Tracheo-esophageal fistula		Since birth	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
3 3-8-65		tracheo-esophageal fistula		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 7 19 65 to March 10 19 65, that (we) last saw the deceased alive on March 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
S. Darryl Fisher, MD				3-10-65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DR. D. FISHER.				JOHNS HOPKINS HOSP., BALTO. 5, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Removal		3/10/1965				Mercersburg, Pa.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 11 1965		Robert E. Starkey		W. J. Fisher & Sons		Balto. Md 21217	

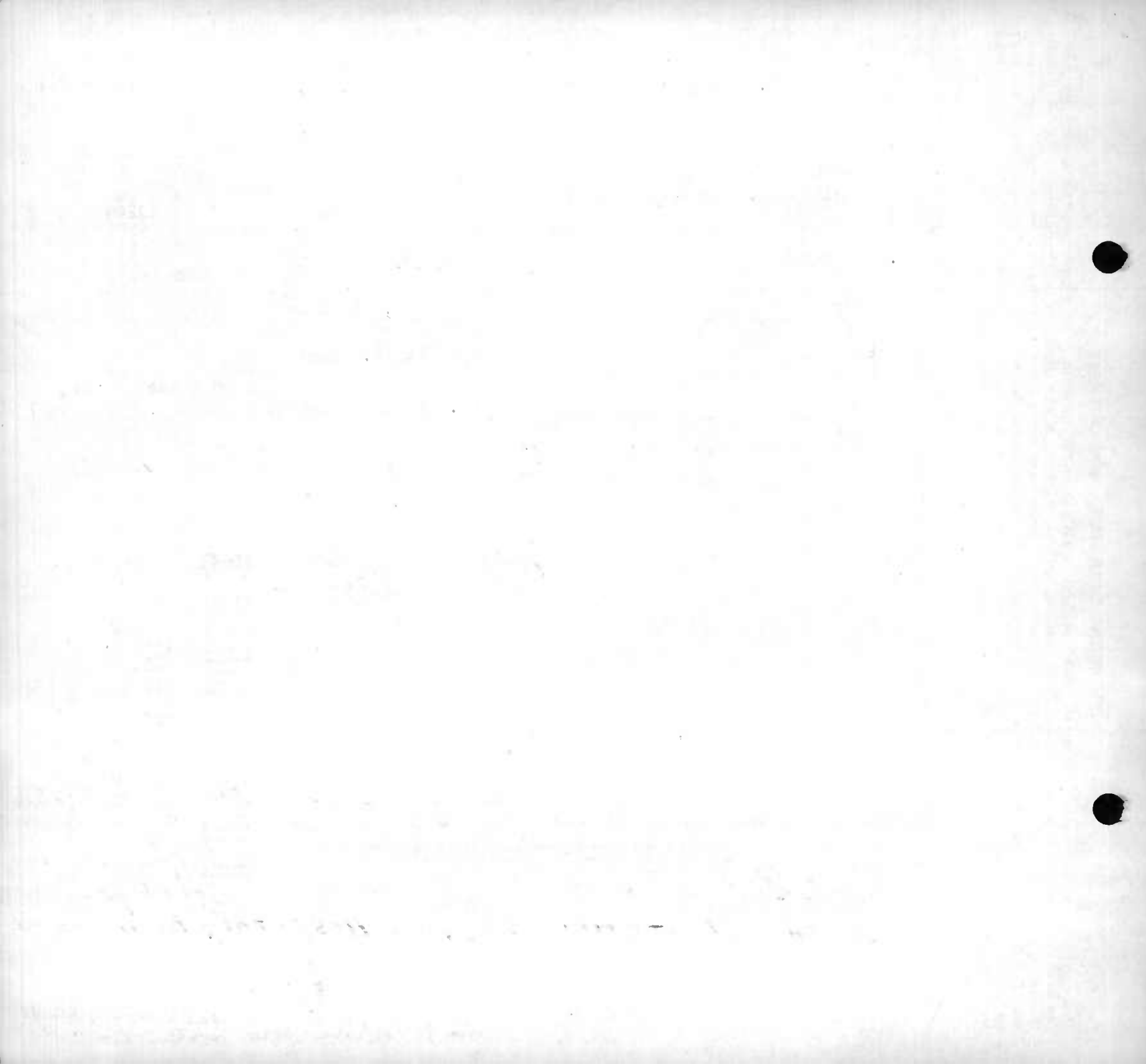




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

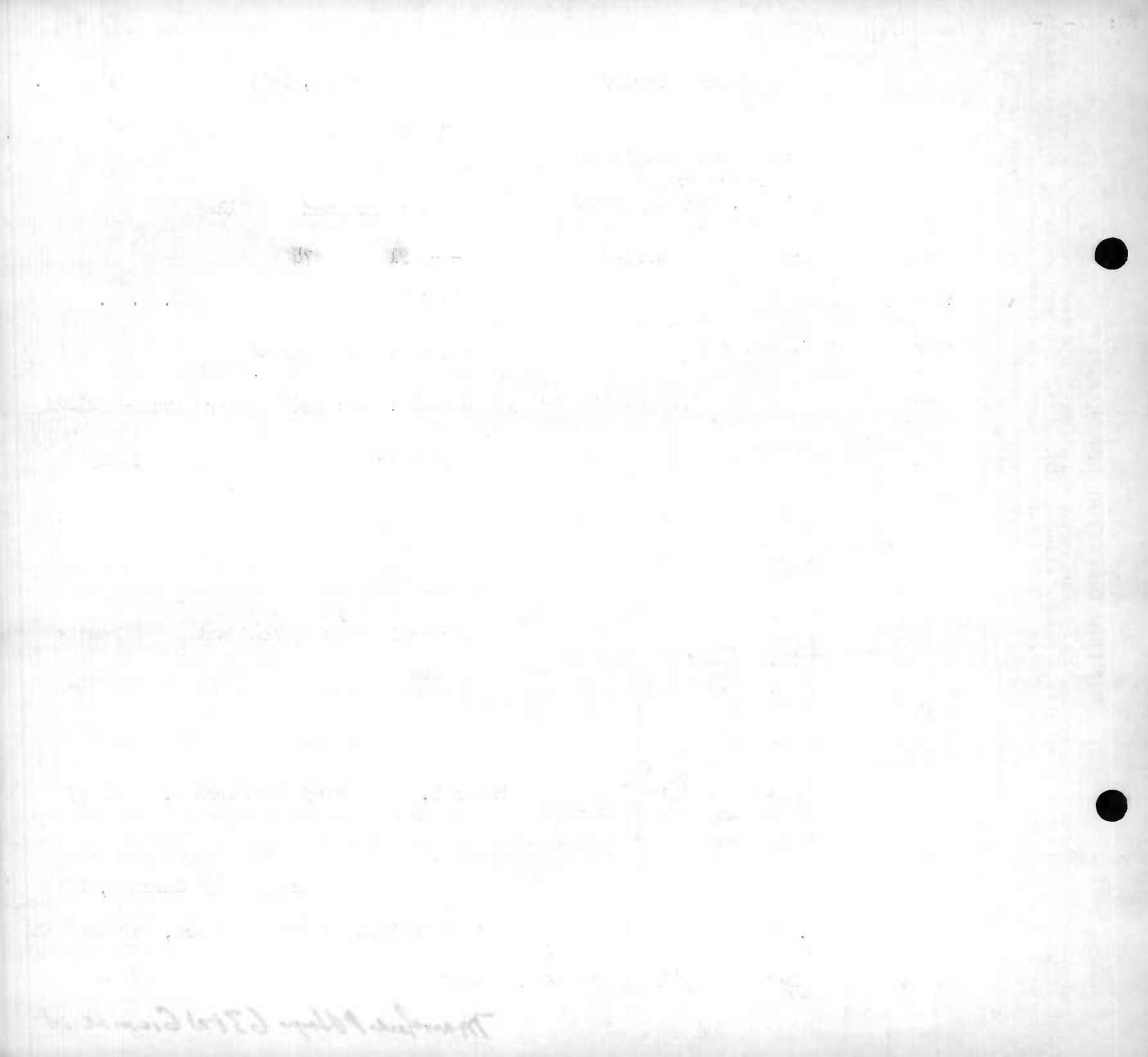
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 2653</b>	
BIRTH NO. <b>65 2653</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Mary E. Hurley Huntzberry</b>			2. DATE AND HOUR OF DEATH <b>March 9, 1965 10:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3000 Wayne Avenue Baltimore, Maryland 21207</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>28-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3000 Wayne Avenue 21207</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>April 17, 1890 74</b>	9. AGE (In years last birthday) <b>74</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Lynchburg, Virginia</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Francis Hurley</b>			14. MOTHER'S MAIDEN NAME <b>Lillian E. Eades</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Margaret Cimbolo Baltimore, Maryland 7</b>		
18. I <b>171X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Ca of cancer with metastases 2 yrs</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertension, Cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>Sept 20 19 62</b> to <b>March 9 19 65</b> , that (H) (we) last saw the deceased alive on <b>March 9 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph C. Matchar</b>			23B. DATE SIGNED <b>3/10/65</b>		
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH C. MATCHAR M.D.</b>			23D. ADDRESS <b>S. NAH HOSPITAL, BALTIMORE, MD</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/13/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Rose Hill Cemetery</b>	
24D. LOCATION <b>Hagerstown, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 11 1965</b>			
25B. NAME OF REGISTRAR <b>R. L. E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Johnson - Sons Baltimore, Md. 17</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 2654</b>	
BIRTH NO. <b>65 2654</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>James Parker</b>		2. DATE AND HOUR OF DEATH <b>March 9, 1965</b>   <b>1:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>X</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>842 Bethune Road 21225</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1-5-1891</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETAIL LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>James PARKER</b>		14. MOTHER'S MAIDEN NAME <b>Ellen JOHNSON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>225-18-0589</b>		17. INFORMANT ADDRESS <b>RECORDS: BCH: 4940 Eastern Avenue #21224</b>	
18. <b>493X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Cerebral Vascular Accident 4 Months</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 1, 1965</b> to <b>March 9, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 9, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>March 9, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Marvin Schuster</b>		23D. ADDRESS M.D. <b>4940 Eastern Avenue Baltimore, Maryland #24</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>3/14/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>MACEDONIA BAPT.</b>	
24D. LOCATION (City, town, or county) (State) <b>CAROLINE CO. VA.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 11 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Hall</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Manly P. Hays 638 N. Gilemore St</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2655				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2655	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Elizabeth Ann Jones) Bessie Lee Jones				2. DATE AND HOUR OF DEATH March 9, 1965		3:00 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-08 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1220 E. North Avenue 21202			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 7-23-82	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Levin Katin Jones				14. MOTHER'S MAIDEN NAME Elizabeth A. Robinson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Miss Sadye Jones 1220 E. North RECORDS: BCH: 4940 Eastern Avenue #21224			
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (R) Cerebral Vascular Accident (A) DUE TO (B) Arteriosclerotic Cardio Vascular Disease (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Urinary Tract Infection							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 28, 19 65 to March 9, 19 65, that (I) (we) last saw the deceased alive on March 9, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. C. Robert Cooke				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED March 9, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. C. Robert Cooke				23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/13/65		24C. NAME of CEMETERY or CREMATORY Baltimore, Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 11 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS INC. BALTIMORE MARYLAND			





H 300

65 2656

BALTIMORE CITY HEALTH DEPARTMENT

65 2656

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ALLEE

HAYWOOD

2. DATE AND HOUR PRONOUNCED DEAD

March 9, 1965

10:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

412 Bowen Alley

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

8-28-1876

9. AGE (In years  
last birthday)

88

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOMEMAKER

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

FREMONT N.C.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

BURKETT EVANS

14. MOTHER'S MAIDEN NAME

JULIA ANN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Rev. B. T. Haywood 409 McALLISTER ST

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST,

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
3/10/6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

3/11/65

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Wilson N.C.

24A. DATE REC'D BY HEALTH DEPT.

MAR 11 1965

24B. NAME OF REGISTRAR

Robert E. Taylor M.D.

24C. FUNERAL DIRECTOR

Barbara P. Haywood 635 N. Gilmor St

ADDRESS

WALLLEY BOGE

PROBATIONER

1-2-1912

Class 1/2

65 2657 BALTIMORE CITY HEALTH DEPARTMENT 65 2657

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Walter P. Milligan 2. DATE AND HOUR PRONOUNCED DEAD 3/8/65 9:40 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-06

D. STREET ADDRESS (If rural, give location) 1935 E. Lafayette Ave.

5. SEX male 6. RACE colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single 8. DATE OF BIRTH 19 Sept 11 9. AGE (In years last birthday) 33

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Hand, Railway 11. BIRTHPLACE (State or foreign country) Baltimore, Md U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Walter P. Milligan 14. MOTHER'S MAIDEN NAME Sula Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes, War 2. 16. SOCIAL SECURITY NO. 21707-9432 17. INFORMANT ADDRESS 1935 E. Lafayette Ave.

18. CAUSE OF DEATH Arteriosclerotic cardiovascular disease

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 3/9/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 3/11/65 23C. NAME OF CEMETERY or CREMATORY Balt. National 23D. LOCATION (City, town, or county) (State) Balt. Md.

24A. DATE REC'D BY HEALTH DEPT. MAR 11 1965 24B. NAME OF REGISTRAR Robert E. Taylor 24C. FUNERAL DIRECTOR Robert E. Williams 24D. ADDRESS 170-31 Bond St. 21213

NO CONTENT

WALLER HOUSE

WALLER HOUSE

WALLER HOUSE

WALLER HOUSE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2658				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2658	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Jesse J. Fillings</b>				2. DATE AND HOUR OF DEATH <b>March 9/65</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2823 W. Mulberry St.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>20-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 23</b> D. STREET ADDRESS (If rural, give location) <b>2823 W. Mulberry St</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>Married</b>	8. DATE OF BIRTH <b>March 20, 1909</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Food Fair, clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Food Fair</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Fillings</b>				14. MOTHER'S MAIDEN NAME <b>Martha Hoopes</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217 05 3618</b>		17. INFORMANT ADDRESS <b>Mrs. Helen Fillings, 2823 W. Mulberry</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute bronchitis and bronchopneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic bronchitis &amp; emphysema</b>				20 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 5 1945</b> to <b>March 9 1965</b> , that (I) (we) last saw the deceased alive on <b>March 10 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <u>did</u> ) (did not) view the body after death.							
23A. SIGNATURE <b>Kennard Yaffe</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/11/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>KENNARD YAFFE</b>				23D. ADDRESS <b>5501 Forest Park Ave Balto 7 Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/12/65</b>		24C. NAME of CEMETERY or CREMATORY <b>New Freedom Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>New Freedom, Penna.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 11 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D.</b>		ADDRESS <b>4101 Edmondson Ave</b>	





BIRTH NO. 55 2659 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) MARCELLENE JOHNSON		2. DATE AND HOUR PRONOUNCED DEAD March 9, 1965 9:20 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  Provident Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1105 N. Gilmore Street	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH Oct. 26, 1928
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 36
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Laura ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Bertha Braxton		ADDRESS 1031 Mount St.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3/12/65	23C. NAME of CEMETERY or CREMATORY Mt Calvary Cem.
23D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.		24A. DATE REC'D BY HEALTH DEPT. MAR 11 1965	
24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR George A. Kline	
24D. ADDRESS 134 E. N. Calhoun St.			



Charles J. [Signature]

## CERTIFICATE OF DEATH

Registered No.

65 2660

65 2660

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Gearldine Moore

2. DATE AND HOUR OF DEATH

March 9, 1965

10:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2725 Baker Street 21216

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3-23-12

9. AGE (In years  
lost birthday)

52

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Evans Williams

14. MOTHER'S MAIDEN NAME

Rosa Lee Smith

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

230-05-0151

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #24

18. 170X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Carcinoma of Breast  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) Metastases to Central  
DUE TO Nervous System

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work ☐ Not While At Work ☐22. I certify that (I) (this hospital) attended the deceased from March 7, 1965 to March 9, 1965,  
that (I) (we) lost saw the deceased alive on March 9, 1965 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C. R. Cooke

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

March 9, 1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. C. Robert Cooke

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

3-15-65

24C. NAME of CEMETERY or CREMATORY

Arbutus Mem. PK.

24D. LOCATION

(City, town, or county)

(State)

Arbutus, Md.

25A. DATE REC'D BY HEALTH DEPT.

MAR 11 1965

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

George H. Kelam 1348 N. Calhoun St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1  
8-200

65 2661

BALTIMORE CITY HEALTH DEPARTMENT

65 2661

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>MANOLA G. PAGE</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>March 10, 1965</b> <b>2:30 P.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>407 Rosebank Avenue</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>407 Rosebank Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 29, 1894</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Thomas Milton Jones</b>				
14. MOTHER'S MAIDEN NAME <b>Amelia Pfeifer</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO. _____			17. INFORMANT <b>Dr. N. Edgar Page</b> ADDRESS <b>(Same)</b>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Heart Disease.</b> INTERVAL BETWEEN ONSET AND DEATH _____ DUE TO (A) _____ (B) _____ (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes Mellitus.</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3/10/65</b>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>3/13/1965</b>	23C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
24A. DATE REC'D BY HEALTH DEPT. <b>MAR 11 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		24C. FUNERAL DIRECTOR ADDRESS <b>H. W. Jenkins &amp; Sons Co. 4905 York Road Baltimore, 12, Md.</b>			

WALLEY BOULE

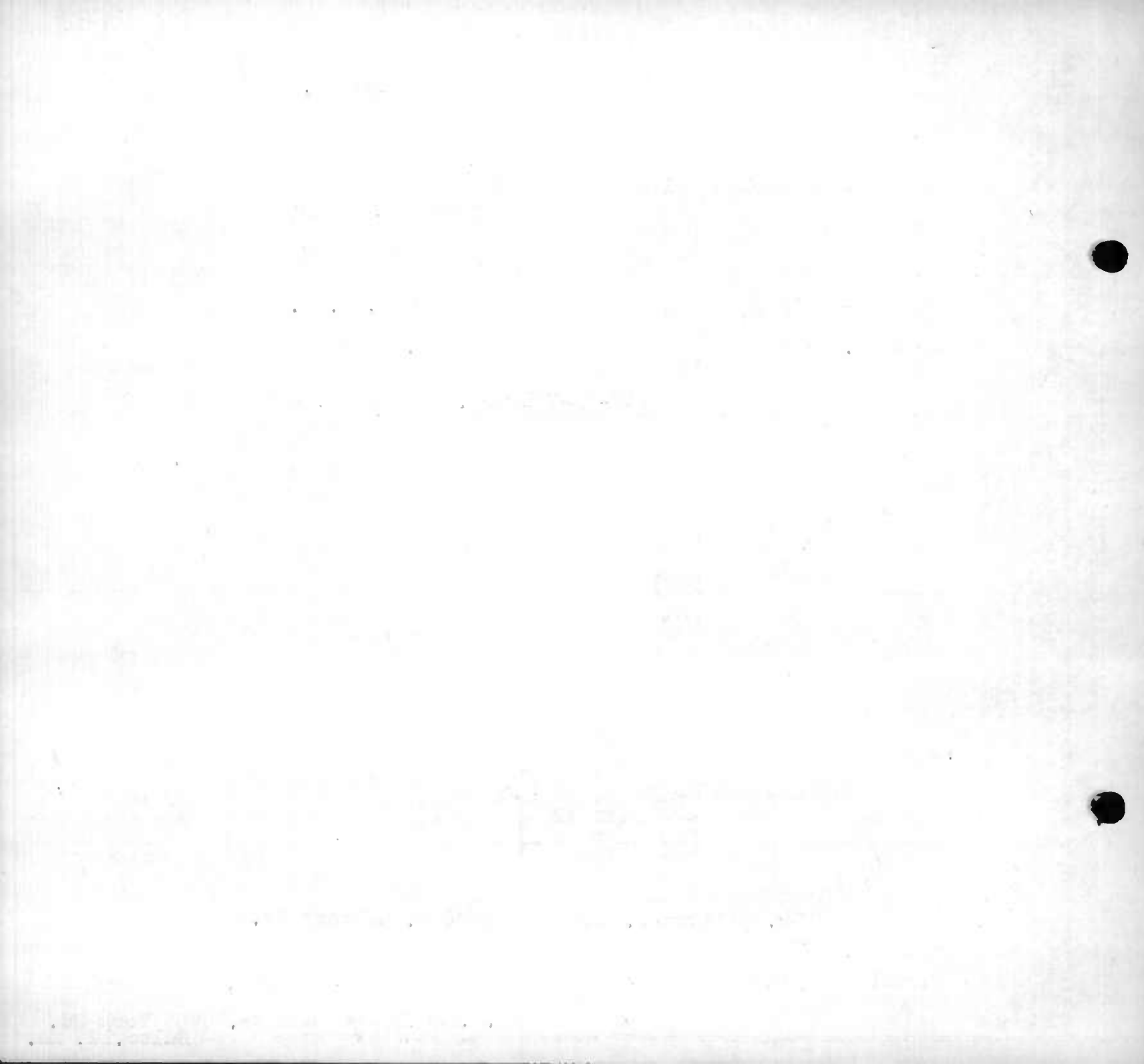
FOR CO. 1111

*Handwritten signature*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

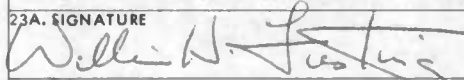
BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 65 2662					CERTIFICATE OF DEATH			Registered No. 65 2662			
1. NAME OF DECEASED (Type or Print) <b>Crawford Heath</b>					2. DATE AND HOUR OF DEATH <b>March 8, 1965</b> <b>7:30 A. M.</b>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1003 Marlau Drive</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-48</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1003 Marlau Drive</b>						
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>8/4/1890</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman-Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>	11. BIRTHPLACE (State or foreign country) <b>Shallotte, N. C.</b>		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>Osgood P. Heath</b>					14. MOTHER'S MAIDEN NAME <b>Anna L. Potts</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>219-03-7618</b>	17. INFORMANT <b>Mrs. Elfriede R. Heath</b>			ADDRESS <b>(Same)</b>				
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Angina Pectoris</b> <b>Coronary Arteriosclerosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Pulmonary Emphysema, Diffuse many years</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH <b>20 years</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>2-1-1965</b> to <b>3-7-1965</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>3-7-1965</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.											
23A. SIGNATURE <b>William P. Benson</b> M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>3-9-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. William P. Benson</b> M.D.					23D. ADDRESS <b>3506 N. Calvert St.</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/10/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 11 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>							

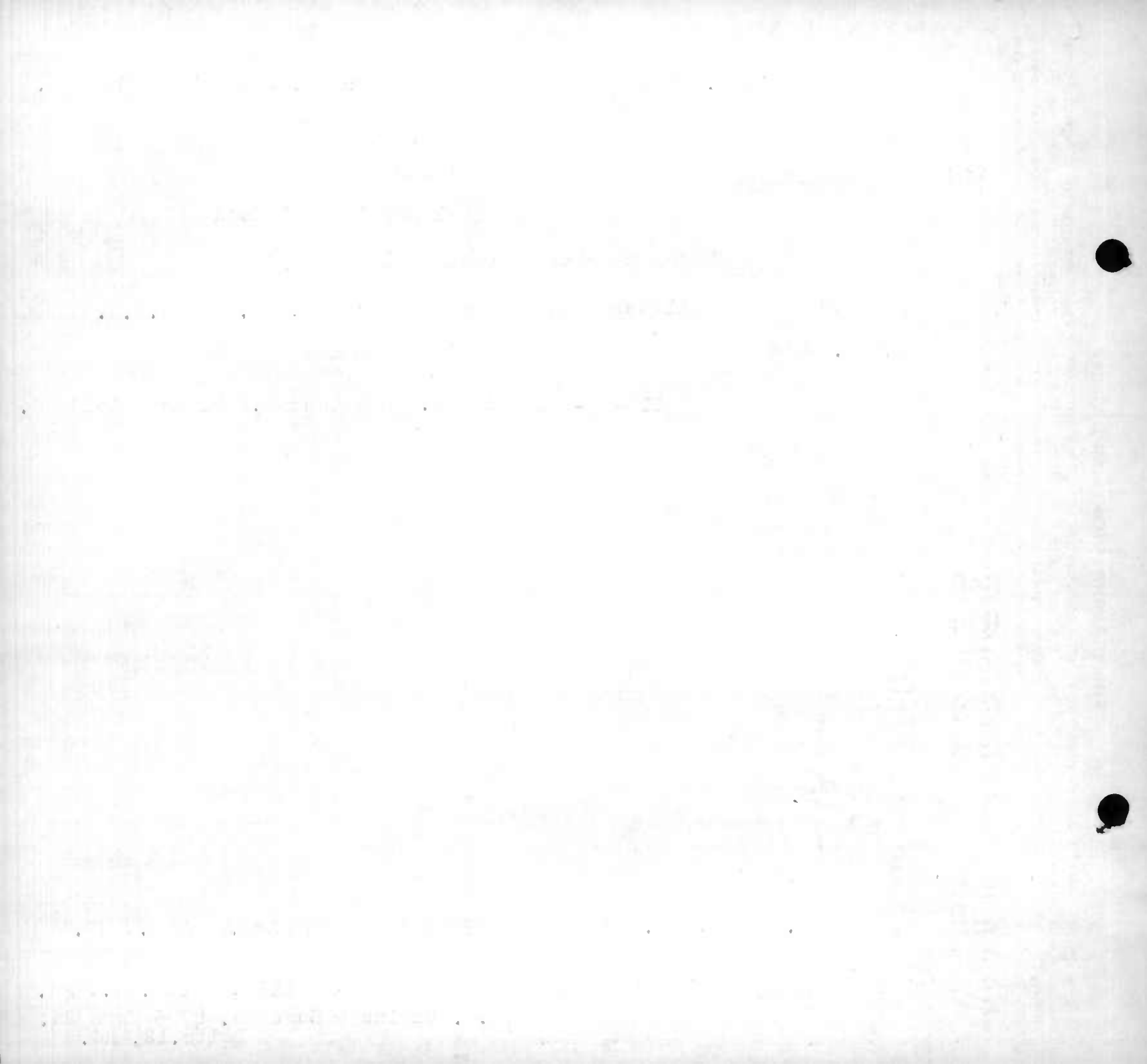




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

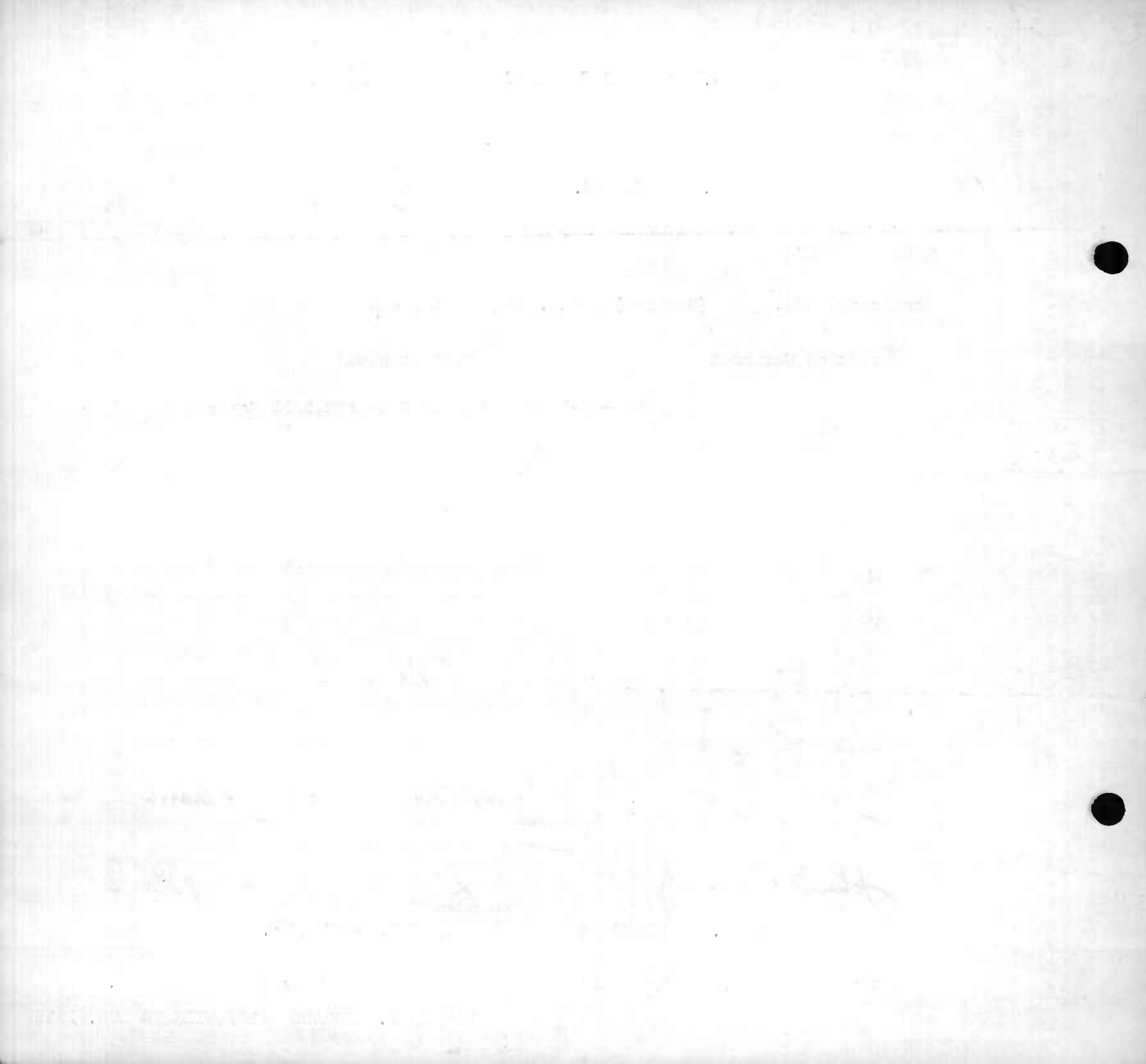
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 2663</span>	
BIRTH NO. <span style="font-size: 1.5em;">65 2663</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mamie W. Ford		March 9, 1965   11:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Edgewood Nursing Home			Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			4421 Marble Hall Road		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
F	W	Never Married	9/16/1881	83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Proprietor		Millinery Shop		Somerset County, Md.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Samuel S. Ford			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			219-32-5817		Miss A. Wanda Landon, 1521 Sheffield Rd.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Cardio-Vascular Disease		
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 3 1965 to March 9 1965, that (I) (we) last saw the deceased alive on March 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED	
M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				3-11-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. William H. Fusting				4230 Loch Raven Blvd. Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/12/65		Druid Ridge Cemetery	
				Pikesville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 11 1965		Robert E. Jenkins		H. W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2664	
BIRTH NO. 65 2664		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CHARLES A. GERNHART		2. DATE AND HOUR OF DEATH 3/9/65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1703 N. CASTLE ST.		A. STATE MARYLAND B. COUNTY 8-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1703 Castle St			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/8/84	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Eng.		10B. KIND OF BUSINESS OR INDUSTRY (Retired) Balto. City Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Christian Gernhart			14. MOTHER'S MAIDEN NAME Myra Bromwell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-40-6314		17. INFORMANT ADDRESS Minnie Gernhart, 5552 Gayland Rd. 27	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Coronary occlusion DUE TO (B) Arterio-sclerotic hypertensive DUE TO (C) Cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 15 October 19 51 to 9 March 19 65, that (I) (we) last saw the deceased alive on 9 March 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE John W. Barnaby				23B. DATE SIGNED 9 Mar 65	
23C. PHYSICIAN'S NAME (Type) JOHN W. BARNABY		23D. ADDRESS M.D. 1531 E. NORTH AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/13/65		24C. NAME of CEMETERY or CREMATORY Druid Ridge	
				24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 11 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD 4107 WILKENS AVE. 21229	

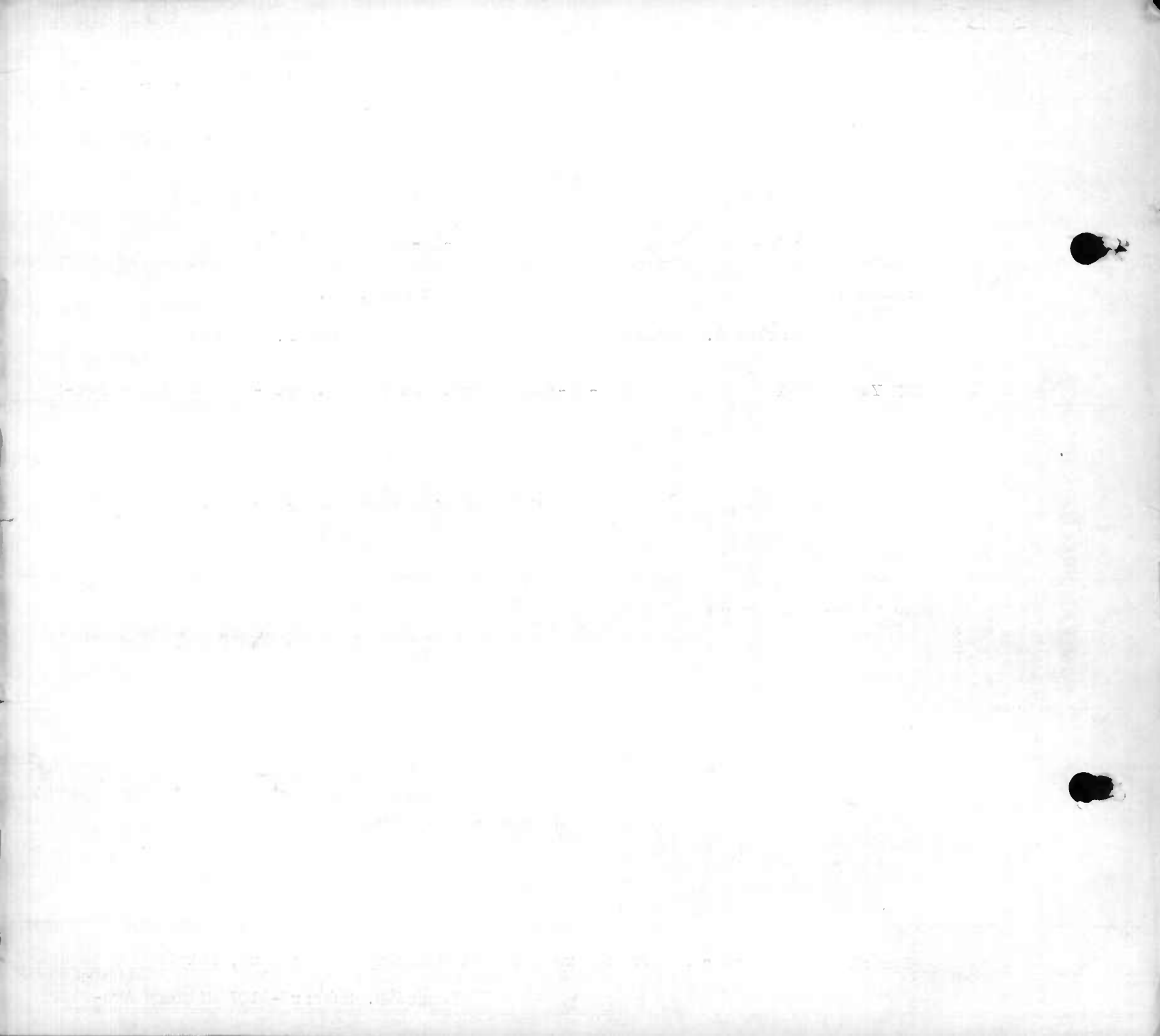


B-254

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

Baltimore City Health Department				Registered No. 65 2665	
BIRTH NO. 65 2665		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>William Bokman</b>	
2. DATE AND HOUR OF DEATH <b>3-9-65 8:55 A.M.</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>37 MERCY HOSP INC.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>4-01</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO</b>		D. STREET ADDRESS (If rural, give location) <b>19 N. HOLIDAY ST.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b>	8. DATE OF BIRTH <b>8-15-98</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Charles A. Bockman</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Schmidt</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>XXX Yes WWI</b>		16. SOCIAL SECURITY NO. <b>216-09-2042</b>		17. INFORMANT ADDRESS <b>Mrs. Margaret E. Byrd-3625 Coolidge Ave-29</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <b>CVA</b> DUE TO (B) <b>Anteriosclerotic Cardiovascular Disease</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II RELEASED BY MR STONE - Med Examiner's Office			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>3-9-1965</b> to <b>3-9-1965</b> that (I) <b>(we)</b> last saw the deceased alive on <b>3-9-1965</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Daniel J. Foss</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/9/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Daniel J. Foss</b>		23D. ADDRESS M.D. <b>Howard H. Hubbard-4107 Wilkens Ave-21229</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-12-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. STATE <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 11 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard-4107 Wilkens Ave-21229</b>	

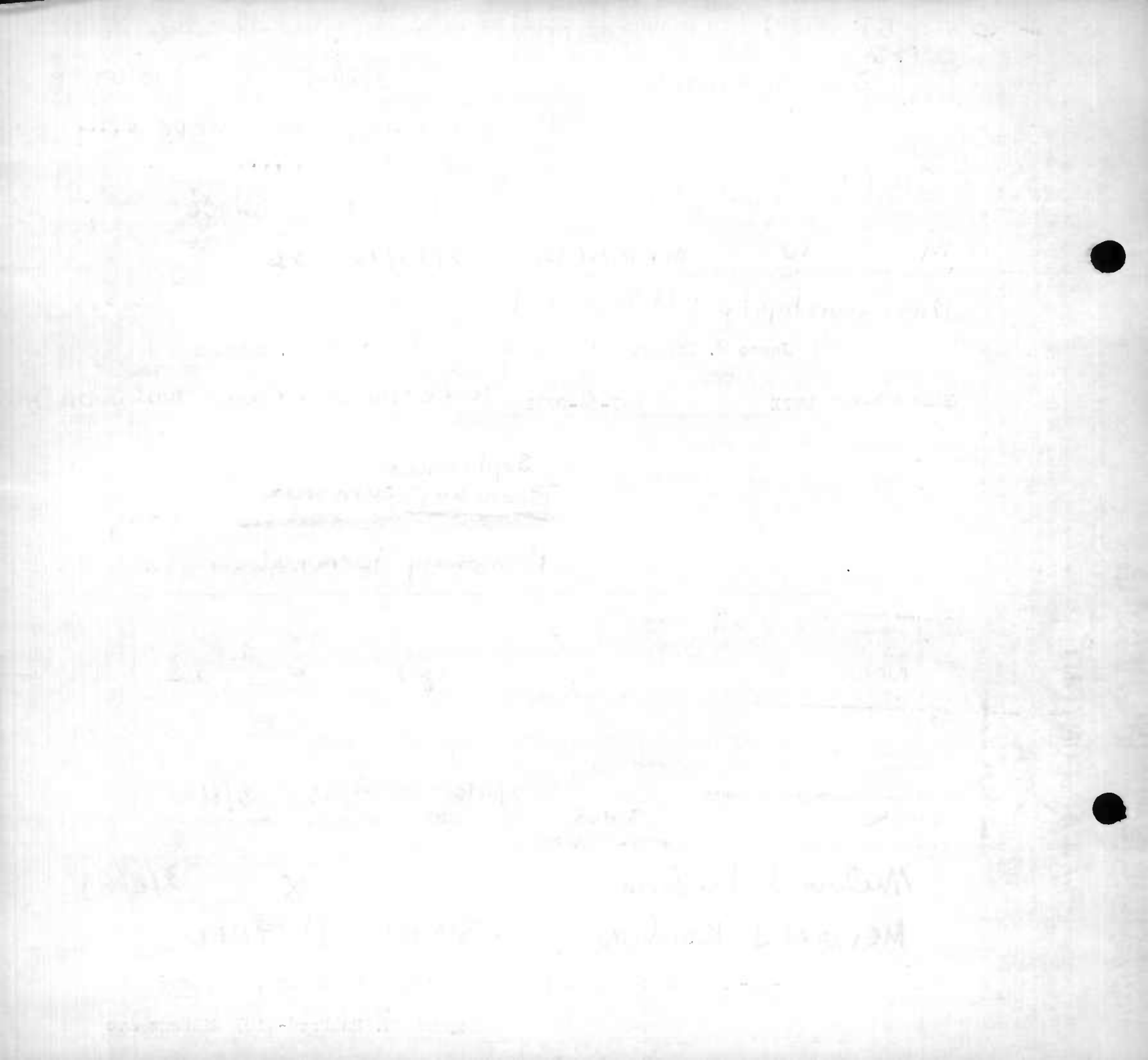


# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2666		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2666	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) DONALD KINSER		3/8/65		10:07 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		A. STATE MARYLAND		B. COUNTY BALTIMORE CITY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE CITY 5300	
		D. STREET ADDRESS (If rural, give location)		700 LINDA DRIVE	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3/27/28	9. AGE (In years lost birthday) 36	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Private investigator		10B. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) Tenn.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Jesse W. Kinser		14. MOTHER'S MAIDEN NAME Gladys E. Roberts	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES KNOWN WWII		16. SOCIAL SECURITY NO. 217-24-0732		17. INFORMANT Wife - Barbara Kinser	
18. 231X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septicemia Bronchopneumonia Pulmonary Adenomatosis		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 day 3 months	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 2/14/65 to 3/8/65, 1965, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (Did) (Did not) view the body after death.					
23A. SIGNATURE Melvin J. Kordon		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/8/65	
23C. PHYSICIAN'S NAME (Type) MELVIN J. Kordon		M.D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-12-65		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 11 1965		25B. NAME OF REGISTRAR R. E. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard	
				ADDRESS 4107 Wilkens Ave	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2667				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2667	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Erria Lee Wilson</b>				2. DATE AND HOUR OF DEATH <b>March 8, 1965 10 PM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address at location)		A. STATE <b>Maryland</b>		B. COUNTY <b>7-08</b>	
<b>1908 N Aisquith St</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		D. STREET ADDRESS (If rural, give location) <b>1908 Aisquith St</b>	
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>Aug 5, 1888</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Green</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Green</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Gertrude Reed</b>		ADDRESS <b>1908 Aisquith St</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Basal Cell Carcinoma of face with metastases</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 11 1964</b> to <b>MARCH 8 1965</b> , that (I) (we) last saw the deceased alive on <b>FEB 12 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Bernard Harris Sr</b>				M.D. Attending <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff <input type="checkbox"/>		23B. DATE SIGNED <b>3/11/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Bernard Harris Sr</b>				23D. ADDRESS <b>1202 N Caroline St Baltimore Md</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-12-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>St Calvary Em A A Co</b>		24D. LOCATION (City, town, or county) (State) <b>Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 11 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Stash, M.D.</b>		25C. FUNERAL DIRECTOR <b>Rufus Sanders</b>			
				ADDRESS <b>2176 Preston St</b>			

1. 10. 1891

London

My dear Sir,  
I have the pleasure to inform you that the  
order for the purchase of the  
shares of the  
company has been  
received and the  
same have been  
transferred to the  
name of the  
company.

I have also the pleasure to inform you that the  
dividend of the  
company for the  
year 1890 has been  
paid and the  
same has been  
transferred to the  
name of the  
company.

I am, Sir, very  
truly,  
Yours,  
J. H. B. B.

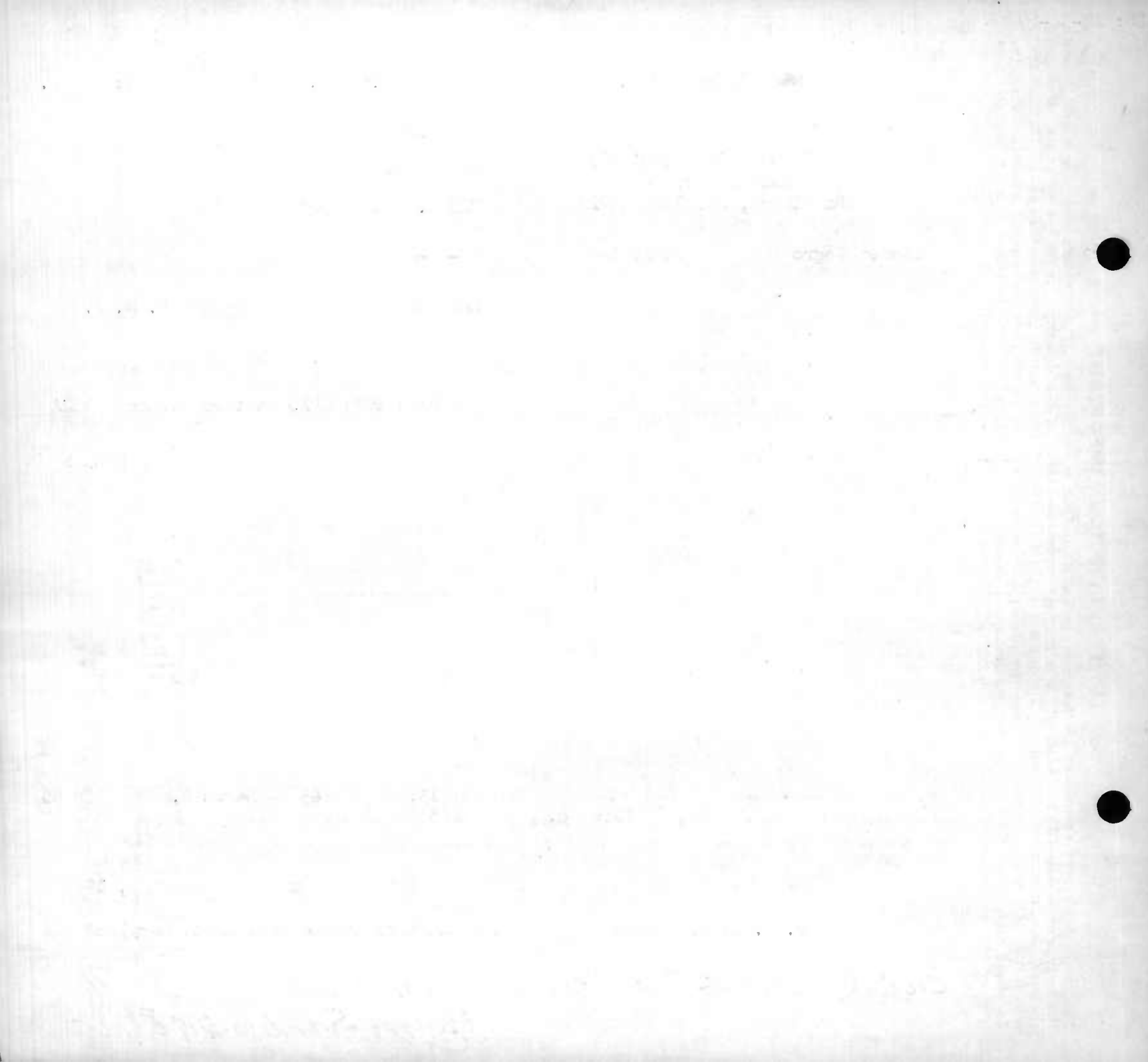
Yours faithfully,  
J. H. B. B.

19-12-34-69 10

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2668		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2668	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mildred Hines		2. DATE AND HOUR OF DEATH March 6, 1965 3:00 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 723 E. 20th Street 21218			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 12-28-24	9. AGE (In years last birthday) 40	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Weldon Watkins		14. MOTHER'S MAIDEN NAME Ora Harris	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224	
18. 1992 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma (A) DUE TO  (B) DUE TO  (C) DUE TO  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 6 Months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 13, 1965 to March 6, 1965, that (I) (we) last saw the deceased alive on March 6, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. R. Cooke		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED March 6, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. C. Robert Cooke		23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-10-65		24C. NAME of CEMETERY or CREMATORY Mt Auburn Em Balto	
24D. LOCATION (City, town, or county) (State) Md		25A. DATE REC'D BY HEALTH DEPT. MAR 11 1965			
25B. NAME OF REGISTRAR R. E. Stab		25C. FUNERAL DIRECTOR Rogner Sanders 217 E Preston St			

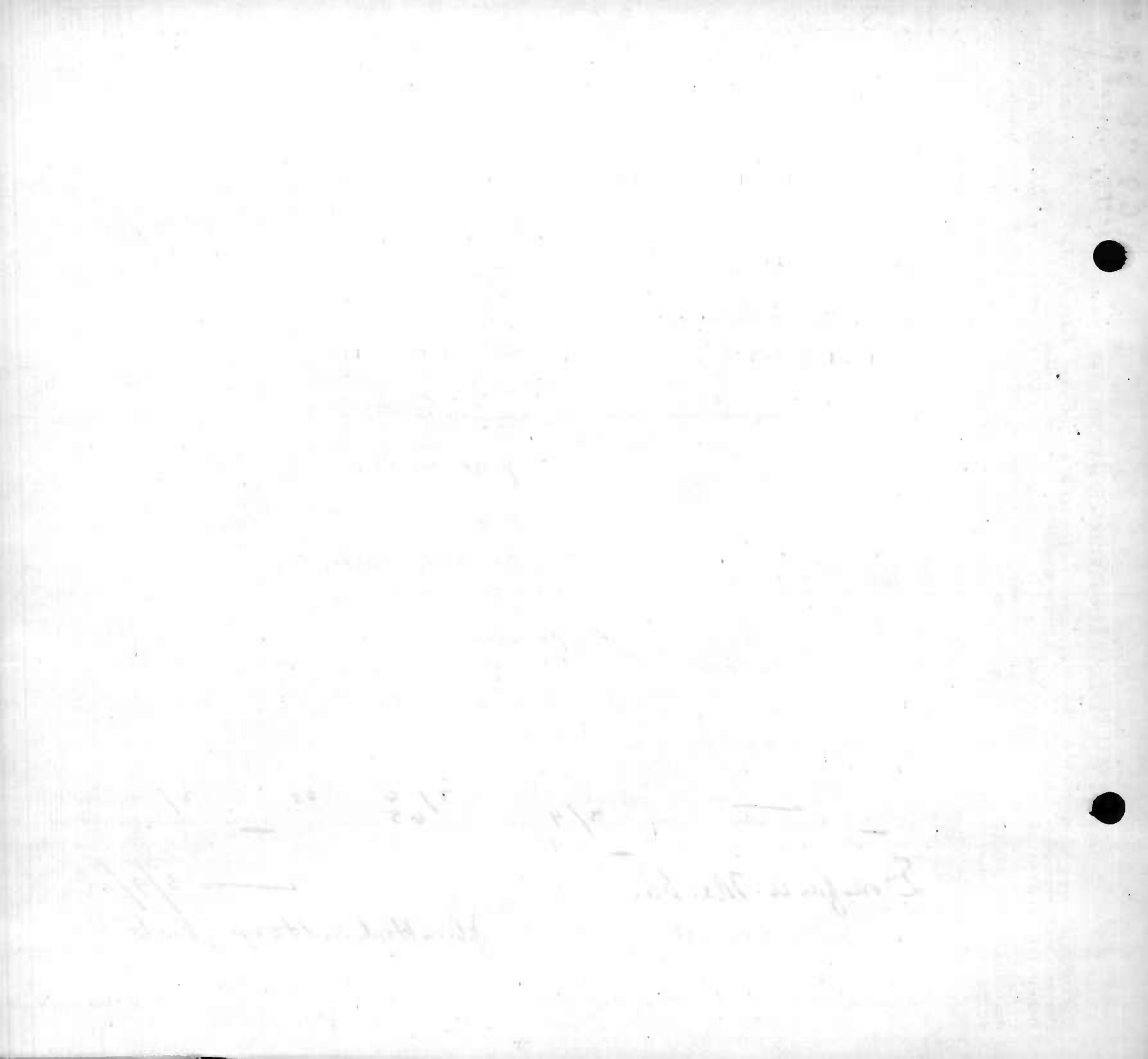


109 98 532  
B-320

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2669 B-320				BALTIMORE CITY AND COUNTY		Baltimore	
M.E. CASE NO.				CERTIFICATE OF DEATH		Registered No. 65 2669	
1. NAME OF DECEASED (Type or Print) <b>BATES, ROBERT L.</b>				2. DATE AND HOUR OF DEATH <b>March 9, 1965 5:30 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>LUTHERVILLE</b>				D. STREET ADDRESS (If rural, give location) <b>200 MORRIS AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11-7-86</b>	9. AGE (In years last birthday) <b>82 78</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Professor - Retired V.M.I.</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>WILLIAM BATES</b>			14. MOTHER'S MAIDEN NAME <b>SUSAN SMITH</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family Records</b>		
18. <b>163X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>pneumonia</b>			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Adenocarcinoma of lung</b>			(B) DUE TO <b>with metastases to brain</b>			<b>1 1/2 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>hypo adrenalism</b>						<b>8 months</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/6 19 65</b> to <b>3/9 19 65</b> , that (I) (we) last saw the deceased alive on <b>3/9 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Douglas W. MacRae</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/9/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>DOUGLAS MACRAE</b>				23D. ADDRESS <b>Johns Hopkins Hosp., Balt Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal/Burial</b>		24B. DATE <b>Mar. 11, 1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Masonic Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Middleway, West Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>		25B. NAME OF REGISTRAR <b>R. E. E. E. E.</b>		25C. FUNERAL DIRECTOR <b>John Burns Sons, Towson, Maryland</b>		ADDRESS	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>65 2670</b>		<b>CERTIFICATE OF DEATH</b>		65 2670	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ELIZABETH REVYUK</b>		March 9, 1965 1:25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Johns Hopkins Hospital Baltimore, Md. 21205</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Kent</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Kennedysville 6400</b>			
		D. STREET ADDRESS (If rural, give location) <b>-</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1923 4 2</b>	9. AGE (In years last birthday) <b>42</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>R.H. Maytag</b>			14. MOTHER'S MAIDEN NAME <b>Ma. B. Kennedy</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT ADDRESS <b>MICHAEL REVYUK, KENNEDYSVILLE, MD.</b>		
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>199-2 I METASTATIC CARCINOMA</b>					<b>4 MOS</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/17 1964</b> to <b>3/9 1965</b> , that (I) (we) last saw the deceased alive on <b>3/9 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard C. Arbogast</b> M.D.				23B. DATE SIGNED <b>3/9/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARD C. ARBOGAST</b>		23D. ADDRESS <b>J.H.H. Hospital</b> M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>3/11/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>BLOOMFIELD FARM</b>		24D. LOCATION (City, town, or county) (State) <b>KENNEDYSVILLE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkes, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Victor M. Kennedy STILL POND, MD.</b>	

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65 2671

BALTIMORE CITY HEALTH DEPARTMENT

65 2671

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ESTELLA PFISTER

2. DATE AND HOUR PRONOUNCED DEAD

3-7-65

1 6:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Pasadena

D. STREET ADDRESS (If rural, give location)

Box 113 - Route 5

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug. 16, 1909

9. AGE (In years  
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

---- Goldstraw

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

James J. Pfister - Rt. 5, Box 113, Pasadena, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Barbiturate intoxication  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Rt. 5 - Box 113  
Pasadena, A. A. Co., Maryland21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
3 7 65 5:30 PM21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingested overdose of barbiturate

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

3-8-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3-11-1965

23C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION

(City, town, or county)

(State)

Ritchie Hwy., A.A.Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 12 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

George J. Gonce

ADDRESS

4001 Ritchie Hwy.

Baltimore 1, Md.

WALLEY-KOPPE

WALLEY-KOPPE

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2672		<b>CERTIFICATE OF DEATH</b>		Baltimore City Health Department		Registered No. 65 2672	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MARY HATCH</b>				MARCH 9, 1965 11 05 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL OF BALTIMORE INC</b>				A. STATE & B. COUNTY <b>MARYLAND, BALTIMORE</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>WOODSTOCK 63-00</b>			
				D. STREET ADDRESS (If rural, give location) <b>CAVEY LANE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>3/21/82</b>	9. AGE (In years lost birthday) <b>82</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Gustav Walter</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>HOSPITAL ADMISSION RECORD</b>		ADDRESS	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCT</b> (A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCUD + RHD</b> (B) DUE TO							
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Intestinal Obstruction <sup>244</sup> to incarcerated hernia.</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>(he)</del> (this hospital) attended the deceased from <b>MARCH 8 1965</b> to <b>MARCH 9 1965</b> , that <del>(he)</del> (we) last saw the deceased alive on <b>MARCH 9 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>(he)</del> (We) (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <b>Samuel M. Muher</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/9/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>SAMUEL MUHER</b> M.D.				23D. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/13/65</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>512 Cathedral Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Staley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Loring Byers 8728 Liberty Rd. Randallstown</b>			

MARCH 1985

SINAI HOSPITAL OF BALTIMORE INC  
F W M  
3/2/85 85

HOSPITAL

HOSPITAL ADMISSION

ACUTE MYOCARDIAL INFARCT

ASU-D+RHD

Intestinal Obstruction  
YES

MARCH 8, 1985  
MARCH 1, 1985

*Samuel M. Muter*

SINAI HOSPITAL OF BALTIMORE

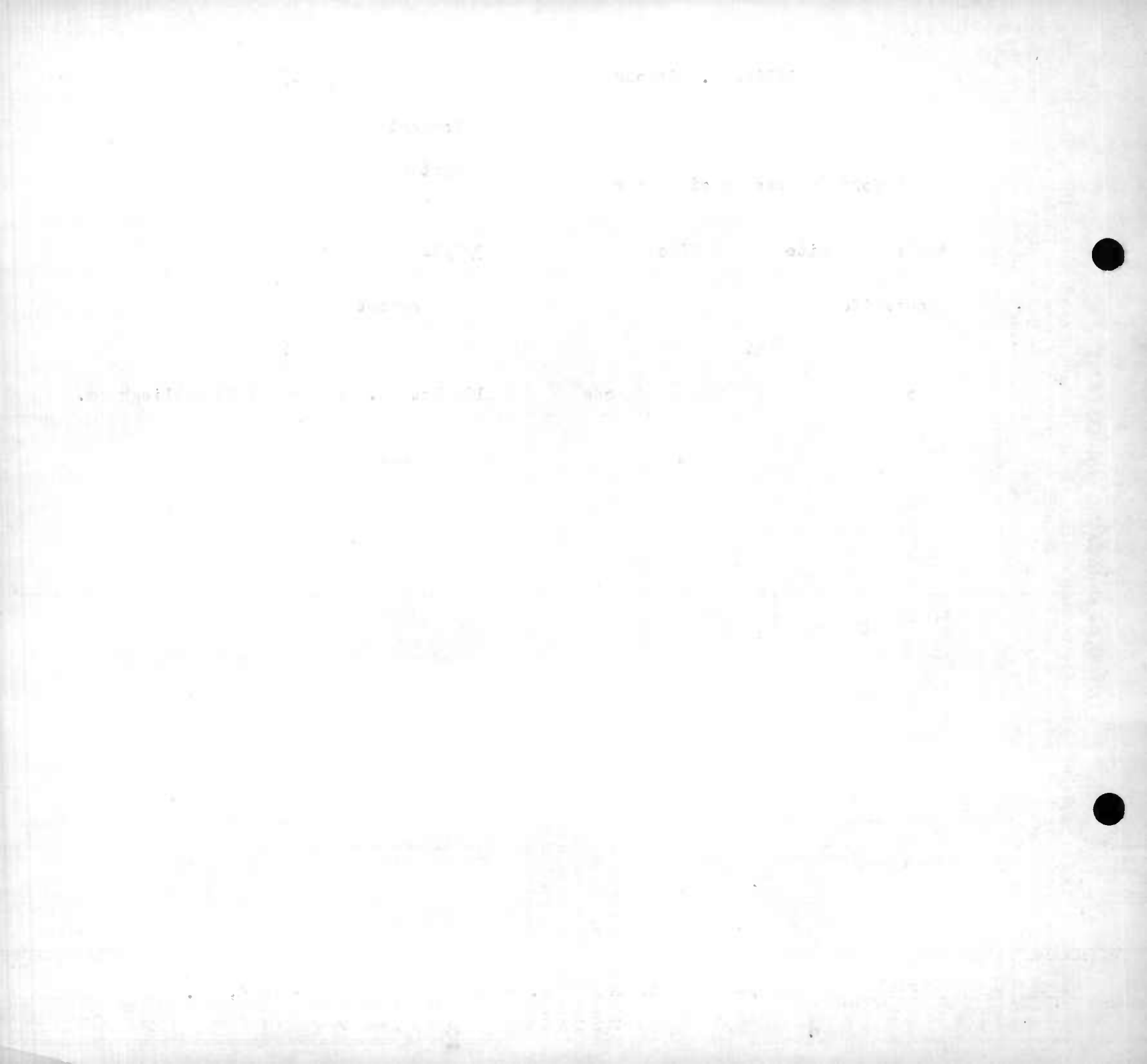


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2673	
BIRTH NO. 65 2673		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lillian C. Gilmour		2. DATE AND HOUR OF DEATH 3/8/65 10:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Harford Gardens Nursing Home		A. STATE B. COUNTY Vermont V-42			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Barton			
		D. STREET ADDRESS (If rural, give location) ?			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 9/7/76	9. AGE (In years last birthday) 88	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Vermont	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Elizebeth G. Newburg 7908 Oakliegh Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Coronary Thrombosis</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1964 19 to March 19 65, that (I) (we) last saw the deceased alive on Mar 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Loy M. Zimmerman</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED March 11 / 65	
23C. PHYSICIAN'S NAME (Type) <i>Loy M. Zimmerman</i>		23D. ADDRESS M.D. 3202 Harford Rd Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/11/65		24C. NAME OF CEMETERY or CREMATORY Moreland Mem. Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. MAR 12 1965		25B. NAME OF REGISTRAR <i>Robert E. Zimmerman</i>		25C. FUNERAL DIRECTOR <i>Paul E. Zimmerman</i>	
				ADDRESS 3617 Chestnut Ave	

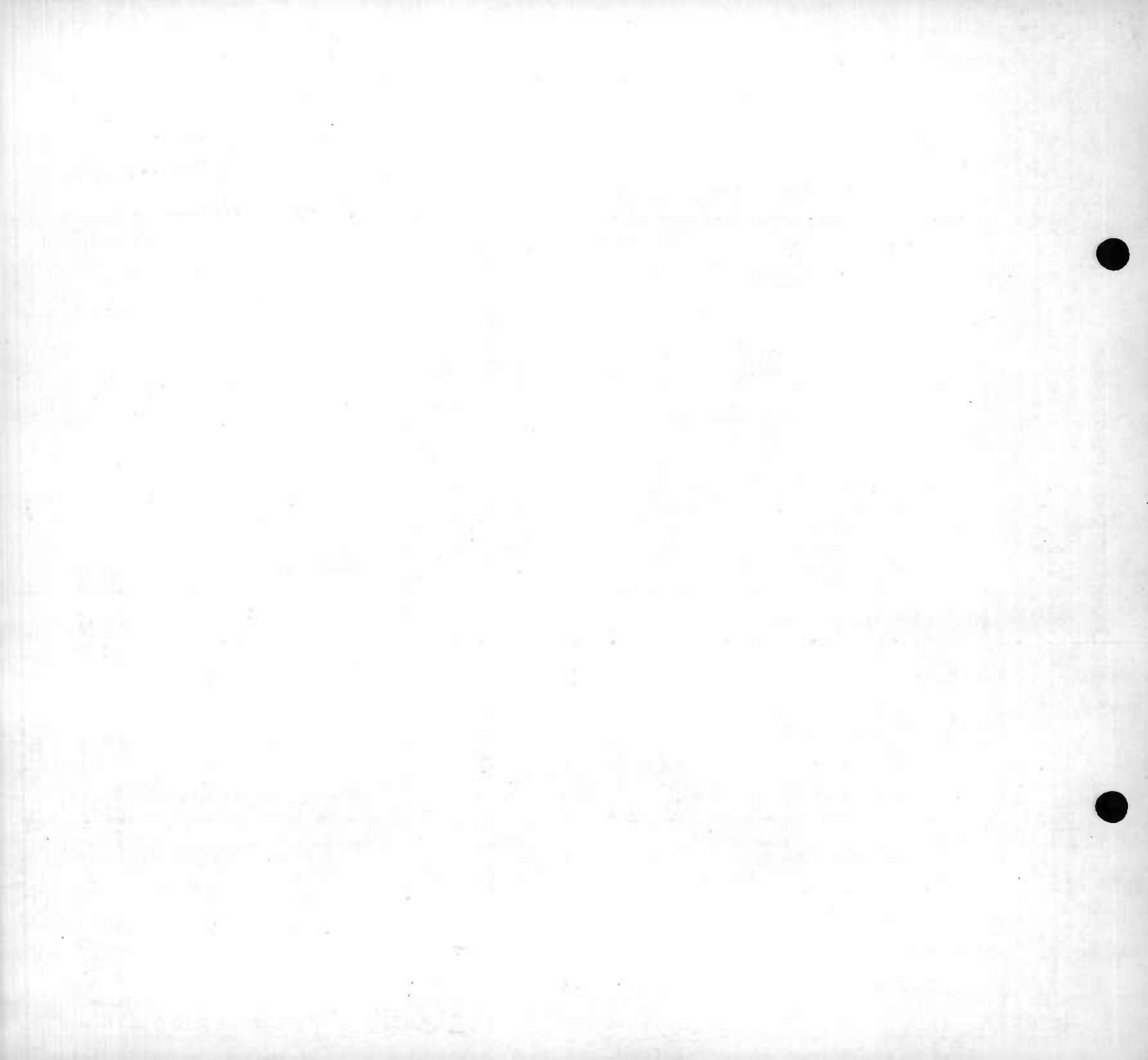




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2674		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2674	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) Brown, Ira Hamilton		2. DATE AND HOUR OF DEATH March 7, 1965 8:25 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 28, Catonsville D. STREET ADDRESS (If rural, give location) 106 Mallor Ave 53-00			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6/17/1888	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A		13. FATHER'S NAME James Brown		14. MOTHER'S MAIDEN NAME Alice Croswell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Lyda Brown Same as above phone RI 7-9631 ADDRESS	
18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) prostatic cancer = metastasis (B) pneumonia (C) pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Feb. 16 19 65 to March 7 19 65, that (I) (we) last saw the deceased alive on March 7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Kyo Rak Lee M.D.		23B. DATE SIGNED March 7, 1965		23C. PHYSICIAN'S NAME (Type) Kyo Rak Lee M.D.	
23D. ADDRESS Franklin Square Hosp.		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 3/11/65		24C. NAME OF CEMETERY or CREMATORY LORRAINE PK. Cem		24D. LOCATION (City, town, or county) (State) Balto Co. Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 12 1965		25B. NAME OF REGISTRAR Robert E. Stasch		25C. FUNERAL DIRECTOR Ed MacNabb ADDRESS Balto 21228 Md	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2675		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2675	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Annie Kistler		March 9, 1965 4:20 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Rural		5300	
D. STREET ADDRESS (If rural, give location)		7858 Gough Street		21224	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Female	White	Widowed	9-18-70	94	11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Etchison		Mary Elliott		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				RECORDS: BCH: 4940 Eastern Avenue #24	
18. 493X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Bacterial Pneumonia			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II		Aspiration Pneumonia			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from February 25, 1965 to March 9, 1965, that (I) (we) last saw the deceased alive on March 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
C. C. Cooke				March 9, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. C. Robert Cooke		4940 Eastern Avenue Baltimore, Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/12/65		Gowens Pres. Church Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 12 1965		R. E. F. F. F.		C. C. Cooke	
				ADDRESS	
				300 Main Ave. Balto. 21	

Wm. H. Hall

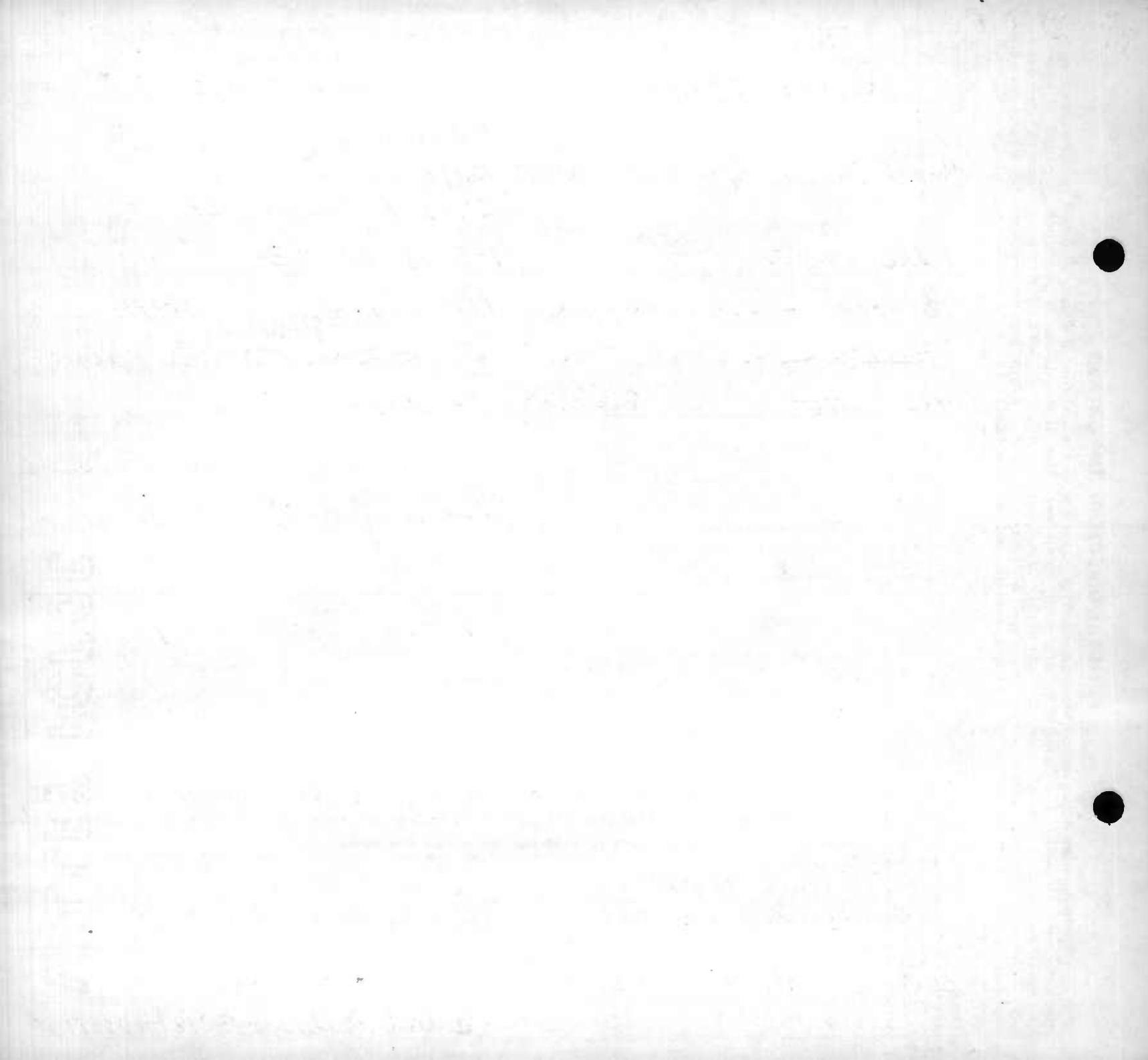
Wm. H. Hall

Wm. H. Hall

FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department									
BIRTH NO. 65 2676					CERTIFICATE OF DEATH			Registered No. 65 2676	
1. NAME OF DECEASED (Type or Print) <b>Pugh, FRANK</b>					2. DATE AND HOUR OF DEATH <b>MARCH 10, 1965 11 25 P.M.</b>				
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1206</b>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>North Charles General Hospital</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				
					D. STREET ADDRESS (If rural, give location) <b>2712 N Charles St.</b>				
5. SEX <b>Male</b>	6. RACE <b>white</b>	7. <del>MARRIED</del> NEVER MARRIED <b>WIDOWED</b> DIVORCED (specify)		8. DATE OF BIRTH <b>1-5-1892</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>fainter - self-employed</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Pugh</b>				14. MOTHER'S MAIDEN NAME <b>Lannie Wearl-</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes</b>				16. SOCIAL SECURITY NO. <b>213-033789</b>		17. INFORMANT ADDRESS <b>Charts Hospital</b>			
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>myocardial infarct</b>				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>Coronary sclerosis</b>		<b>10 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)		<b>5 years</b>			
19A. DATE OF OPERATION <b>13/10/65</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Prostatic hypertrophy</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 4 1965</b> to <b>MARCH 10 1965</b> , that (I) (we) last saw the deceased alive on <b>MARCH 10 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>A. Lewis Kolodny</b>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>A. LEWIS KOLODNY</b>						23D. ADDRESS <b>1825 Eastern Blvd. Baltimore 21, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/13/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR <b>Angelo Hoffmann</b>		ADDRESS <b>3218 Hudson St.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		64-02506		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.		65 2677	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
Kevin Blake				March 6, 1965				9:30 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE				B. COUNTY			
Provident Hospital				Maryland				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
1514 Division Street				Baltimore				D. STREET ADDRESS (If rural, give location)			
Baltimore, Maryland				1302 Division Street							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
Male	Negro	Single	1-25-64	1							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
none					Maryland		USA				
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
				Gloria Blake							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			
no			none		Marie Allbrook			4222 Park Heights Ave.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO				Bronchopneumonia			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO							
ANTECEDENT CAUSES				(C) DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2				Yes							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from March 4, 1964 to March 6, 1965, that (I) (we) last saw the deceased alive on March 6, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
Rosaria Bello				March 6, 1965							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
R. Bello				1514 Division Street							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		3/13/1965		Mt. Auburn Cem.		Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
MAR 12 1965		Robert E. Williams		Williams Funeral Home		319 N. Schradn St					



*Approved and Released by Medical Examiner - Mr. [Signature]*

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

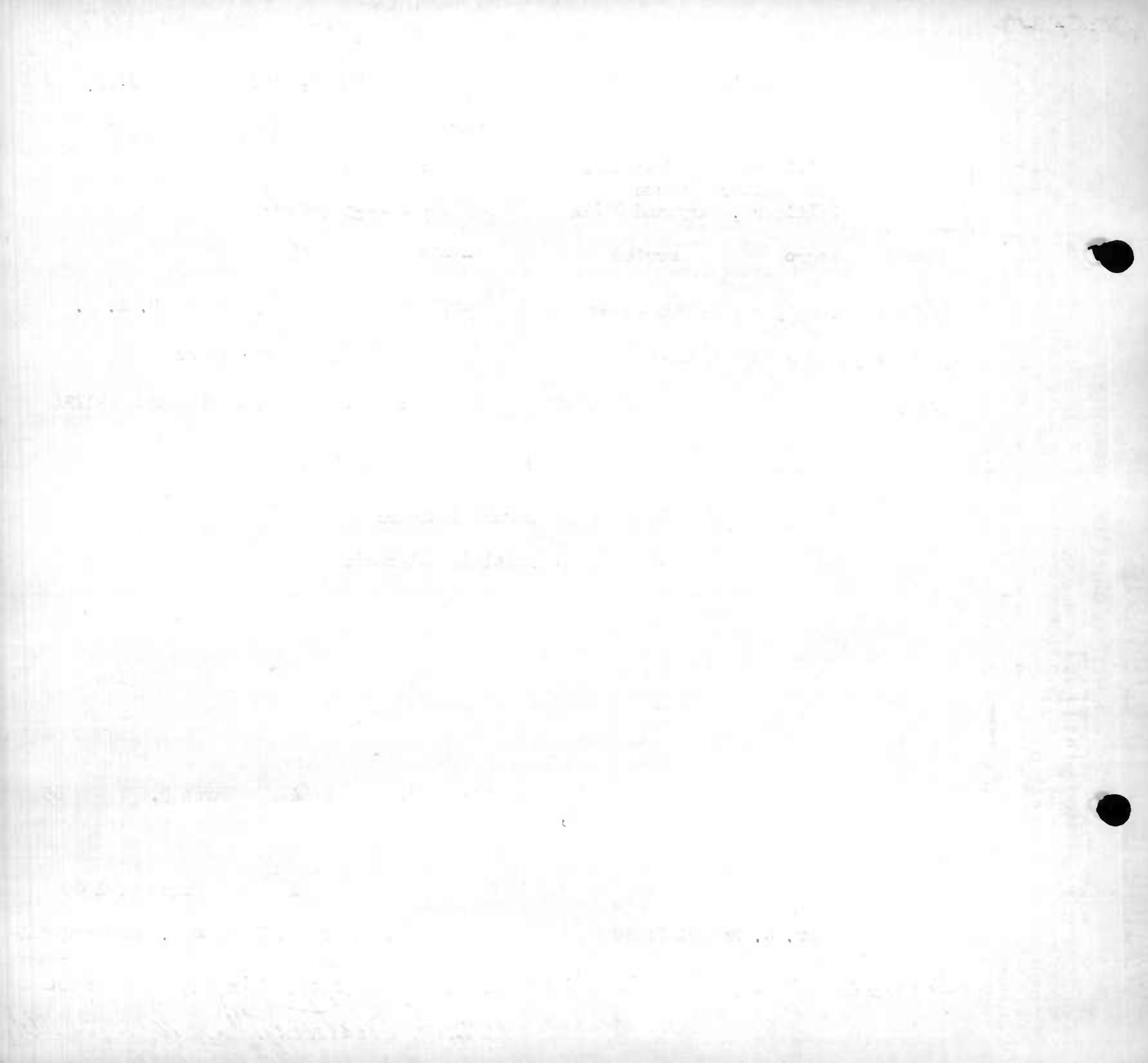
Baltimore City Health Department				Registered No. 65 2678	
BIRTH NO. 55 2678		M.E. CASE NO. 55 2678		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Robert Andrew Moore, Sr.		2. DATE AND HOUR OF DEATH 3/10/65 - 13:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital		A. STATE Maryland B. COUNTY Balts			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53700			
		D. STREET ADDRESS (If rural, give location) 2000 Rollingwood Rd -			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 8/9/09	9. AGE (in years last birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MFG - Representative Manufacturing		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Scranton, Pa.	
13. FATHER'S NAME Michael J. Moore		14. MOTHER'S MAIDEN NAME Annabelle Peake		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 195-10-8812		17. INFORMANT (Son) Robert A. Moore Jr. 21228	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Acute Myocardial Infarction 1-2 hrs. DUE TO (B) Atherosclerotic Cardiovascular Disease DUE TO (C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/10/65 (3:15 AM) 19 65 to 3/10/65 (3:30 AM) 19 65, that (I) (we) last saw the deceased alive on 3/10/65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Miriam L. Cohen		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/10/65	
23C. PHYSICIAN'S NAME (Type) MIRIAM L. COHEN		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/1965		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
				24D. LOCATION Baltimore - Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 12 1965		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR 25 Mac [Signature] - 301 Frederick Road - Md	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2679				BALTIMORE CITY HEALTH DEPT.		Registered No. 65 2679	
M.E. CASE NO. 65 2679				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Sophia Beale</b>				2. DATE AND HOUR OF DEATH <b>March 9, 1965</b> <b>3:55 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>RURAL: Glencoe</b> D. STREET ADDRESS (If rural, give location) <b>Glencoe Rd.</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8-5-18</b>	9. AGE (In years last birthday) <b>46</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lias. Powell</b>		14. MOTHER'S MAIDEN NAME <b>Charollette Harden</b>		17. INFORMANT ADDRESS <b>RECORDS: BCH: 4940 Eastern Avenue #21224</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Gram Negative Septicemia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Decubiti Ulcers</b> <b>Multiple Sclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>September 2, 1964</b> to <b>March 9, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 9, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>C. R. Cooke</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>March 9, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. C. Robert Cooke</b>				23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland #24</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/13/65</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Joseph's</b>		24D. LOCATION (City, town, or county) (State) <b>Texas, Balto. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Cooke</b>		25C. FUNERAL DIRECTOR <b>Wm. L. Hartman Jr.</b>		ADDRESS <b>1701 W. P. Calley Balto. Md.</b>	

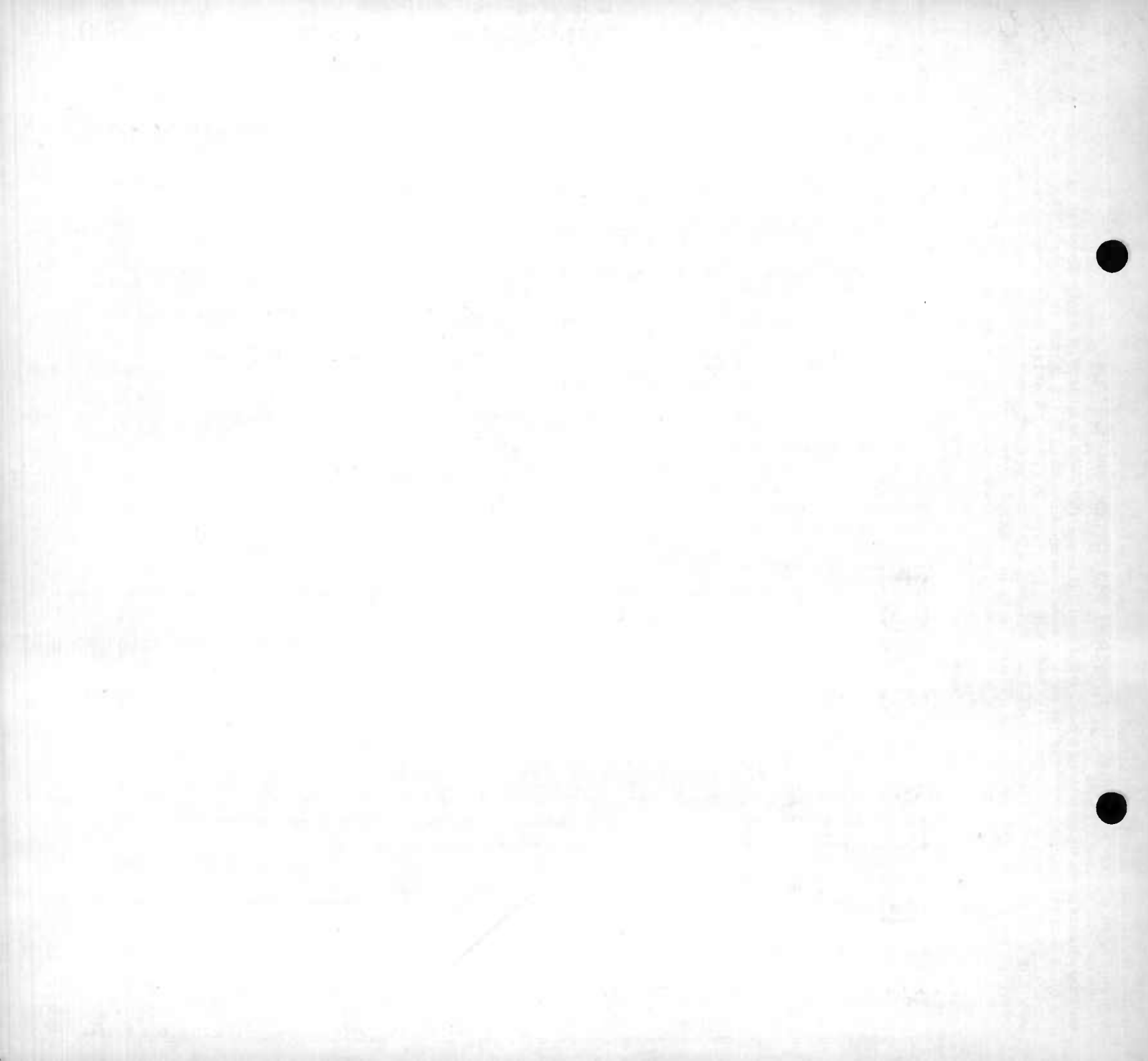


# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2680 4	
BIRTH NO. 65-05668		M.E. CASE NO. 65 2680		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MALOFF BABY GIRL			2. DATE AND HOUR OF DEATH 3-10-65 11:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL (If not in hospital or institution, give street address or location)			A. STATE 3588Y FLANNERY LANE BALTIMORE MARYLAND		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 3533 Flannery Lane		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3-9-65	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY? 17
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE Md.	
13. FATHER'S NAME LOUIS MALOFF			14. MOTHER'S MAIDEN NAME EMMA LIPSTEIN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MOTHER SAME
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) PREMATUREITY DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)			(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C)		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-9-65 to 3-10-65, that (I) (we) lost saw the deceased alive on 3-10-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E.C. CRUZ			23B. DATE SIGNED 3-10-65		
23C. PHYSICIAN'S NAME (Type) E.C. CRUZ			23D. ADDRESS Sinai Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-11-65		24C. NAME of CEMETERY or CREMATORY HERRING RUN	
24D. LOCATION BALTIMORE Md		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. DATE REC'D BY HEALTH DEPT. MAR 12 1965		24H. NAME OF REGISTRAR E. H. HARRIS		24I. FUNERAL DIRECTOR ADDRESS	
24J. DATE REC'D BY HEALTH DEPT.		24K. NAME OF REGISTRAR		24L. FUNERAL DIRECTOR ADDRESS	

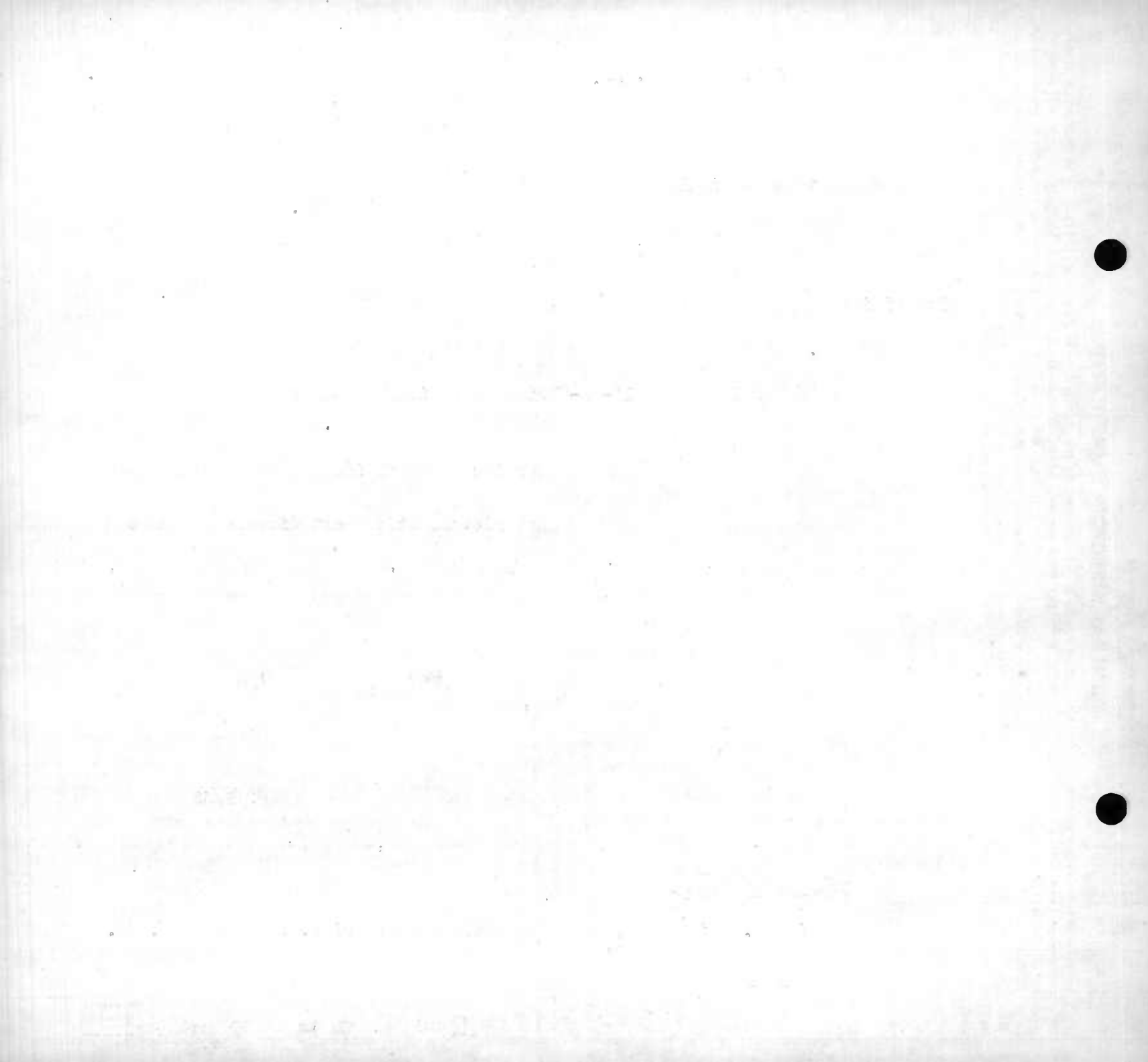




# FUNERAL DIRECTOR: IMPORTANT

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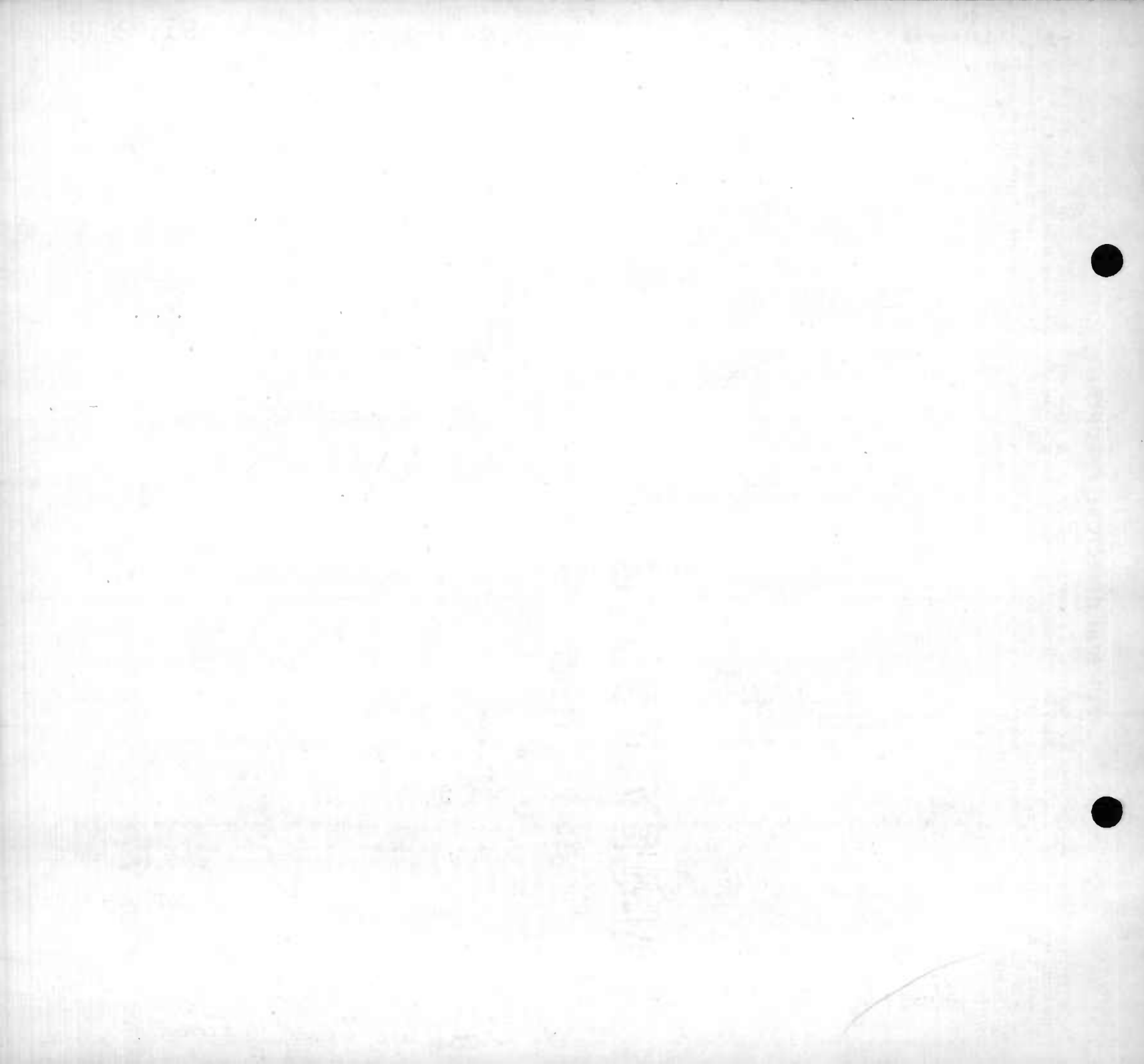
BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>65 2681</u>	
BIRTH NO. <u>65 2681</u>		<b>CERTIFICATE OF DEATH</b>					
M.E. CASE NO. <u>65 2681</u>							
1. NAME OF DECEASED (Type or Print) <u>Ogier, George B. Jr.</u>				2. DATE AND HOUR OF DEATH <u>3/9/65</u>		8:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Montebello State Hospital</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		<u>Balt</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		<u>53-00</u>	
				O. STREET ADDRESS (If rural, give location) <u>7409 Kenlea Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>Married</u>		8. DATE OF BIRTH <u>3/31/97</u>	9. AGE (In years lost birthday) <u>67</u>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Armco Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George B. Ogier</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ella Jewell</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>212-05-7738</u>		17. INFORMANT <u>Hospital Records</u>		ADDRESS	
18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrhythmia</u> (A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Heart disease</u> (B) DUE TO				<u>Unknown</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/10/63</u> 19 to <u>3/9/65</u> 19, that (I) (we) last saw the deceased alive on <u>3/9/65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Daniel G. Lai</u>				M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/9/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Daniel G. Lai</u>				23D. ADDRESS M.D. <u>2201 Argonne Drive, Baltimore 18, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-13-65</u>		24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 12 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Stalder</u>		25C. FUNERAL DIRECTOR <u>Ernesta B. Geitz</u>		ADDRESS <u>5209 York Road, Balto. Md. 21212</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

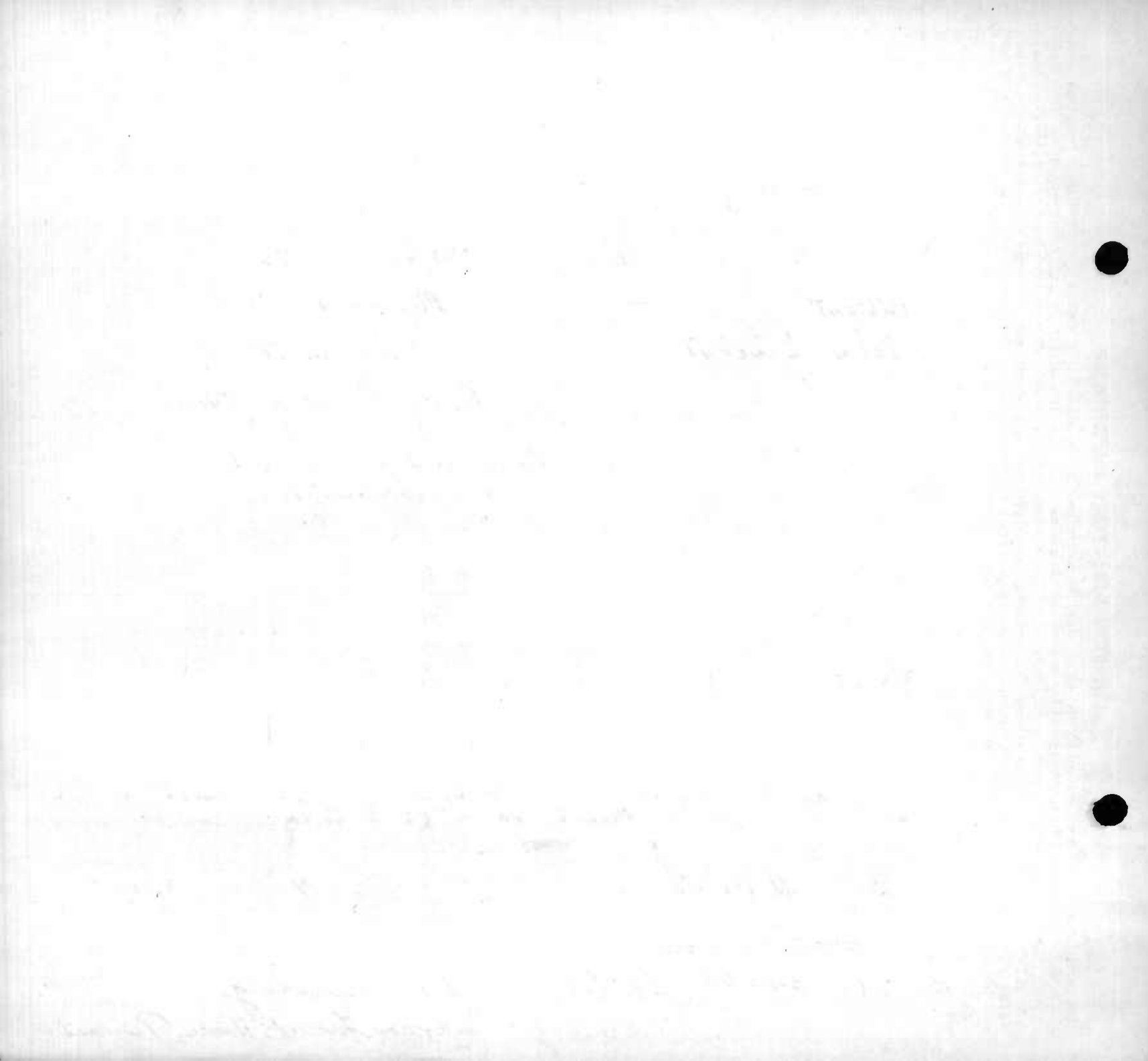
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 2682</u>	
BIRTH NO. <u>65 2682</u>		M.E. CASE NO. <u>65 2682</u>		1. NAME OF DECEASED (Type or Print) <u>ELLIS, EUGENE M.</u>		2. DATE AND HOUR OF DEATH <u>March 10, 1965</u> <u>7P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Joseph's Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>8-03</u>			
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>				8. DATE OF BIRTH <u>Jan. 18, 1894</u> 9. AGE (In years last birthday) <u>71 yrs</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer-Wholesale drug firm</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eugene M. Ellis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Kenealy</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-07-6665</u>		17. INFORMANT <u>Margaret M. Vopalecky</u> ADDRESS <u>7107 Greenwood Ave.</u>	
18. <u>434.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Chronic Heart failure with pulmonary Edema.</u> (B) <u></u> (C) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March 10, 1965</u> to <u>March 10, 1965</u> , that (I) (we) lost the deceased alive on <u>March 10, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Melencio Ventura</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>March 10, 1965</u>			
23C. PHYSICIAN'S NAME (Type) <u>Melencio Ventura</u>				23D. ADDRESS <u>St. Joseph's Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-13-65</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Edmondson Ave Ball Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 12 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>John ...</u>		ADDRESS <u>7101 N. Patterson Park</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2683		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2683	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>MARY LENA BROWN</i>		2. DATE AND HOUR OF DEATH <i>3/10/65</i> <i>7:50 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Belts</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>MT. WILSON STATE Hospital</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i>		D. STREET ADDRESS (If rural, give location)			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>9/15/87</i>	9. AGE (In years last birthday) <i>76</i>	If Under 1 Tr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PATIENT</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Vincent</i>		14. MOTHER'S MAIDEN NAME <i>Mary Smoot</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Ruby Darsey, Newburg, Md.</i>	
18. <i>10-1X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of Stomach &amp; Carcinomatosis.</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>3/4/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Feeding jejunostomy</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLIEING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (we) (this hospital) attended the deceased from <i>Feb. 30</i> 19 <i>65</i> to <i>March 10</i> 19 <i>65</i> , that (we) last saw the deceased alive on <i>March 10</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Bruce H. MacPherson</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED/ <i>3/10/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Bruce H. MacPherson</i>		M.D.		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-13-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Shiloh Methodist</i>	
24D. LOCATION (City, town, or county) (State) <i>Newburg Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 12 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>	
25C. FUNERAL DIRECTOR <i>Johnson Funeral Home Pomeroy, Md.</i>		ADDRESS			

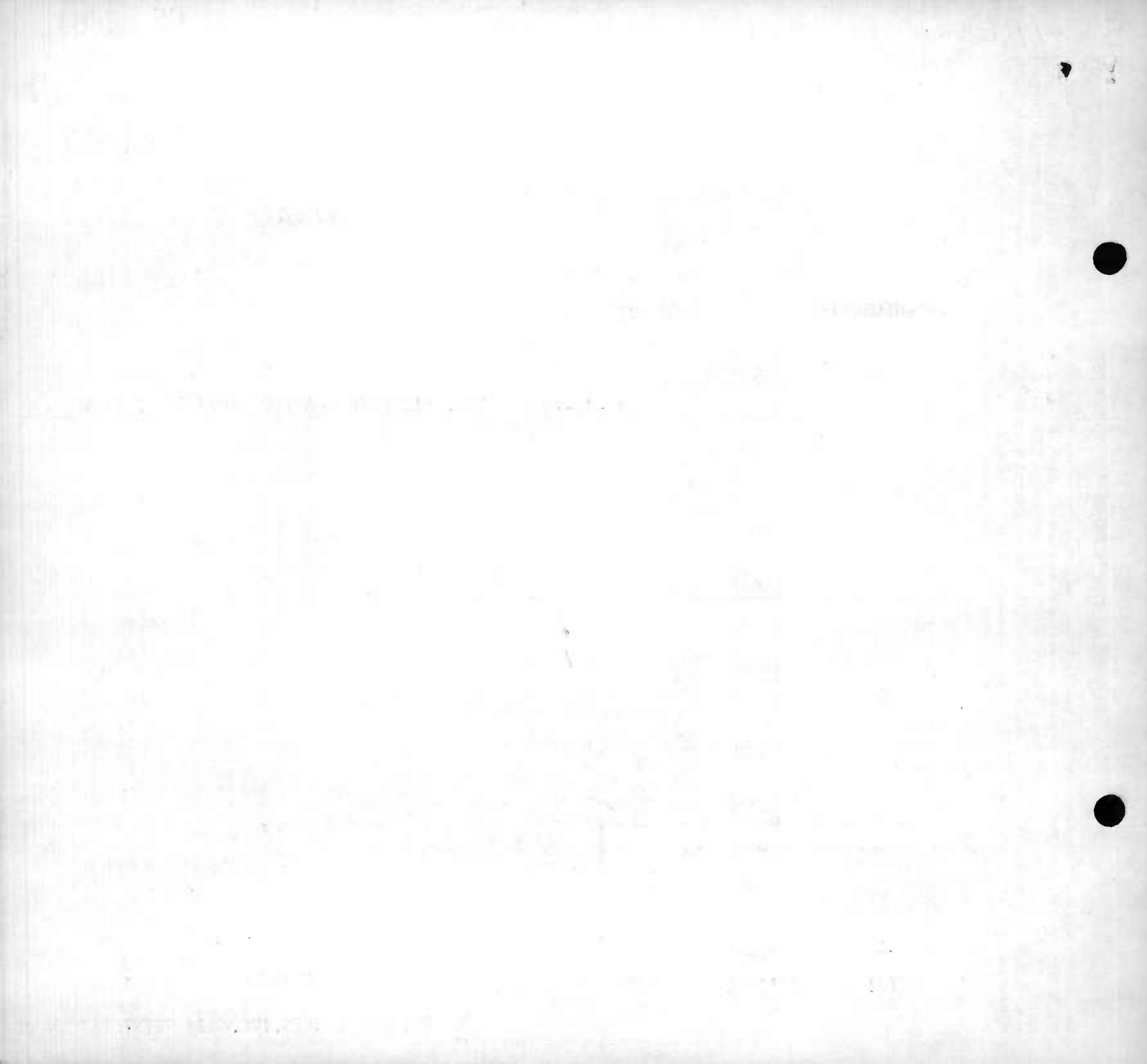




# FUNERAL DIRECTOR: IMPORTANT

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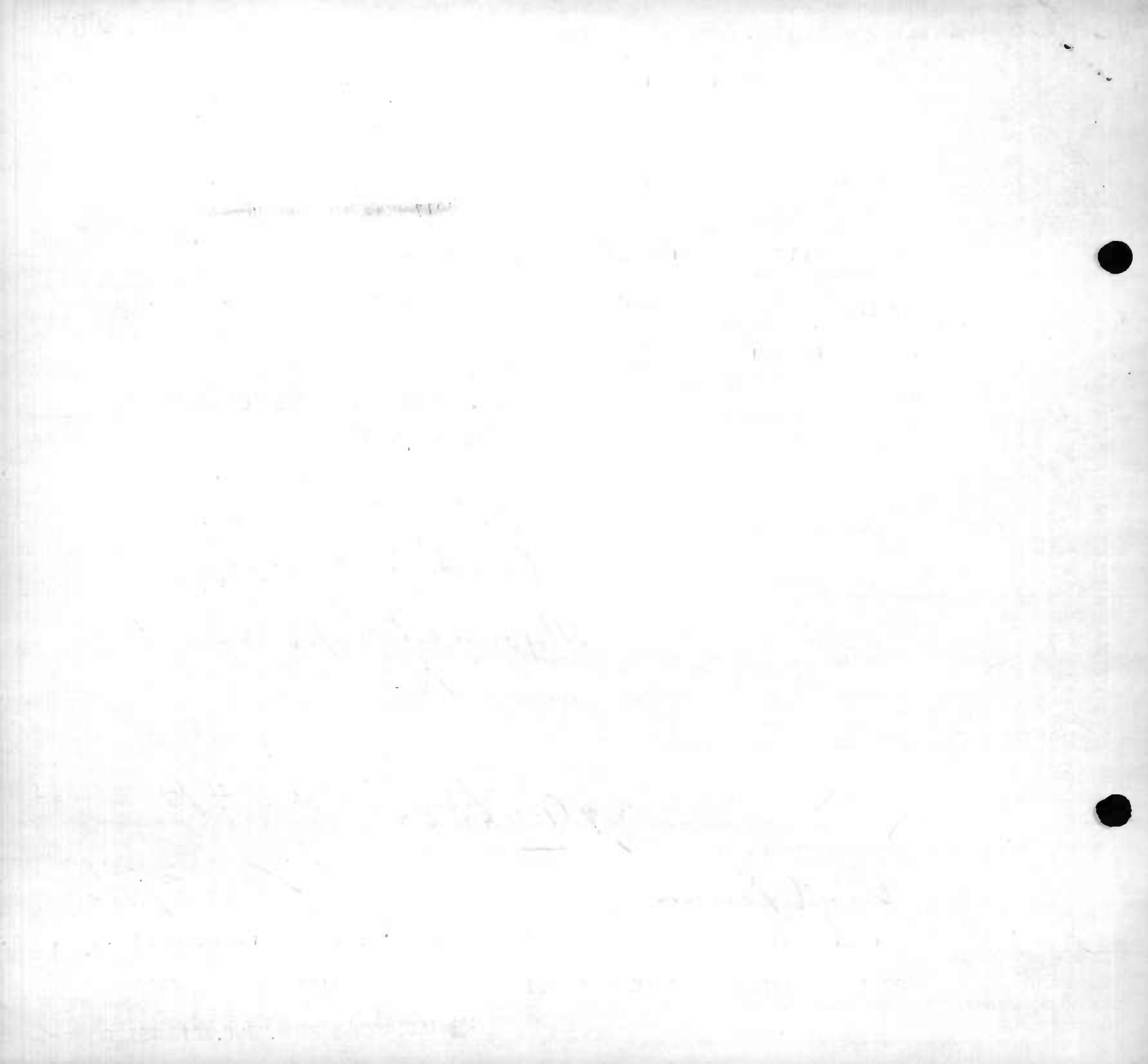
BIRTH NO. 65 2684				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2684	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>HILDA SCHLEIFER</b>			
2. DATE AND HOUR OF DEATH <b>9-March 65 15:00 P. M.</b>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>				A. STATE <b>Md.</b>			
				B. COUNTY <b>Baltimore</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore, Md.</b>				D. STREET ADDRESS (If rural, give location) <b>2600 E. SINORE AVE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>10/30/07</b>	9. AGE (in years lost birthday) <b>57</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME AT MORN</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Saloman Patz</b>				14. MOTHER'S MAIDEN NAME <b>Celia Pumpian</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-18-3488</b>		17. INFORMANT ADDRESS <b>MRS. FLORENCE SHAPIRO 4004 FORDS LANE</b>			
18. <b>153.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Penitontitis</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinoma of Colon</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>13/1/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>2/27/65</b> 19 to <b>3/9/65</b> 19, that (I) (we) last saw the deceased alive on <b>3/9/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Jesse A. Marcel</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/9/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jesse A. Marcel</b>				23D. ADDRESS <b>96 UH Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/11/65</b>		24C. NAME of CEMETERY or CREMATORY <b>BALTIMORE HEBREW</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</b>			



# FUNERAL DIRECTOR: IMPORTANT

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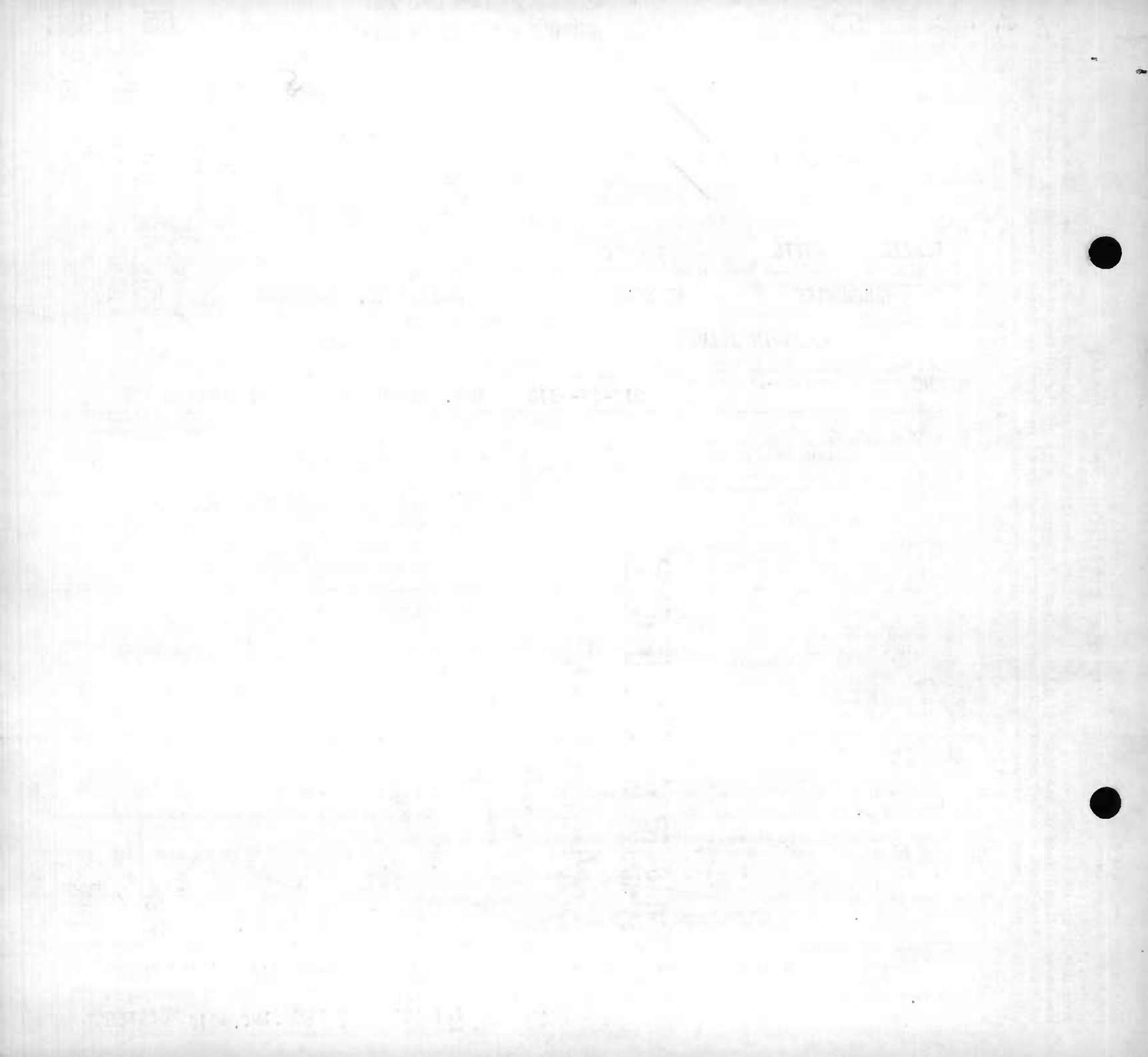
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2685</u>	
BIRTH NO. <u>65 2685</u>		M.E. CASE NO. <u>65 2685</u>			
1. NAME OF DECEASED (Type or Print) <b>JOSEPH BIORSKI</b>			2. DATE AND HOUR OF DEATH <b>3-9-65 7:55AM.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>15-12</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 7</b>		
			D. STREET ADDRESS (If rural, give location) <b>2917 ROCKROSE AVENUE</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>12-12-83</b>	9. AGE (in years lost birthday) <b>81</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SHOP</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>JEROME BIORSKI</b>		
14. MOTHER'S MAIDEN NAME <b>IDA</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>MR. MARCUS BOYER 5525 OLD COURT ROAD</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>			CAUSE OF DEATH <b>Myocardial infarction</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO <b>Gram Neg. Septicemia</b> (B) DUE TO <b>Urinary Tract Infection</b> (C) <b>Benign Prostatic Hypertrophy</b>		
INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>1-2 yrs.</b> <b>15-20 yrs</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Myocardial infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/8</b> 19 <b>65</b> to <b>4/9</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3/9 (1:30 PM)</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Virgil Brown</b>				23B. DATE SIGNED <b>3/9/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>VIRGIL BROWN</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL, BALTO., 5, MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/10/65</b>		24C. NAME of CEMETERY or CREMATORY <b>MISHKON ISRAEL</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>			
25B. NAME OF REGISTRAR <b>SOI LEVINSON</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOI LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2686		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2686	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>SHARP, LEAH</b>		2. DATE AND HOUR OF DEATH <b>3/9/65</b> <b>2 35 P</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE CITY</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> <b>21215 15-10</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL OF BALTIMORE INC.</b>		D. STREET ADDRESS (If rural, give location) <b>3924 BOARMAN AVE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>11/1/07</b>	9. AGE (In years, last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>BENJAMIN SILVER</b>		14. MOTHER'S MAIDEN NAME <b>IDA PLEET</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-24-9313</b>		17. INFORMANT ADDRESS <b>MRS. SARAH LEVIN 3924 BOARMAN AVE</b>	
18. <b>451X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Dissecting Aneurysm of the Ascending &amp; Thoracic Aorta</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>3/9/65</b> 19 <b>65</b> to <b>3/9/65</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3/9/65</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>H. A. Serebro</b> M.D.		23B. DATE SIGNED <b>3/9/65</b>		23C. PHYSICIAN'S NAME (Type) <b>H. SEREBRO M.D.</b>	
23D. ADDRESS <b>Sinai Hospital Baltimore</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/10/65</b>	
24C. NAME OF CEMETERY or CREMATORY <b>TIFEREH ISRAEL ANSHE SFARD</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>	
25B. NAME OF REGISTRAR <b>Robert E. Stoddy, M.D.</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b>		25D. ADDRESS <b>6010 REISTERSTOWN RD</b>	



BIRTH NO. 65 2687 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2687

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Queen Mosley - ESTHER

2. DATE AND HOUR PRONOUNCED DEAD

March 7, 1965

9:56 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

911 E. Madison Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

11-28-1902

9. AGE (In years  
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

LEWIS BLACKWELL

14. MOTHER'S MAIDEN NAME

CLARRIE BLACKWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

WILLIAM MOSLEY 911 E. MADISON

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 7, 1965

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

3-11-65

23C. NAME of CEMETERY or CREMATORY

BALTO-NATIONAL

23D. LOCATION

(City, town, or county)

(State)

BALTO, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 12 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JOSEPH-KNIGHT 1639 N. BROADWAY



WALLS BOFOT

PAID COUNTRY

USA

WC

LEWIS  
KNE

WIDE W

11-23-1912

LEWIS BLACKWELL

WILLIAM MOSELEY PUT ON 11-23-12

Serial 3-11-12 DATE-NATIONAL LEADS, MD.

JOSEPH HUNT 1887-1934

BIRTH NO. 65 2688		BALTIMORE CITY HEALTH DEPARTMENT		65 2688	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) WILLIS GILBERT			2. DATE AND HOUR PRONOUNCED DEAD March 10, 1965 10:45 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE CORRECTED 4-7-65 Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1039 N. Castle Street		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 8-10-1905	9. AGE (in years last birthday) 59	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker		10B. KIND OF BUSINESS OR INDUSTRY Gray Con. Pipe Co.		11. BIRTHPLACE (State or foreign country) N C	
13. FATHER'S NAME unknown			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			14. MOTHER'S MAIDEN NAME Maggie Paterson		
16. SOCIAL SECURITY NO. 238-03-5308			17. INFORMANT Carrie Royter 1039 Castle st		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E900.0			CAUSE OF DEATH (A) Bronchopneumonia DUE TO (B) Craniocerebral Injury. DUE TO (C) _____		
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1039 Castle Street 07-04	
21D. TIME OF INJURY (APPROX.) 2 27 '65 A		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell down cellar steps.	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 3/11/65					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 3-14-65		23C. NAME of CEMETERY or CREMATORY STATESVILLE NC	
24A. DATE REC'D BY HEALTH DEPT. MAR 12 1965		24B. NAME OF REGISTRAR Walter S. Johnson		24C. FUNERAL DIRECTOR JOSEPH K. WRIGHT 1639 N. Broadway	

V.S. 153

4-7-65

M.H.

WALLEN FORD

WALLEN FORD

WALLEN FORD

WALLEN FORD

Classified

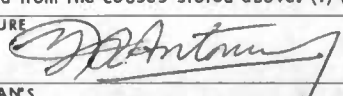
3-14-62

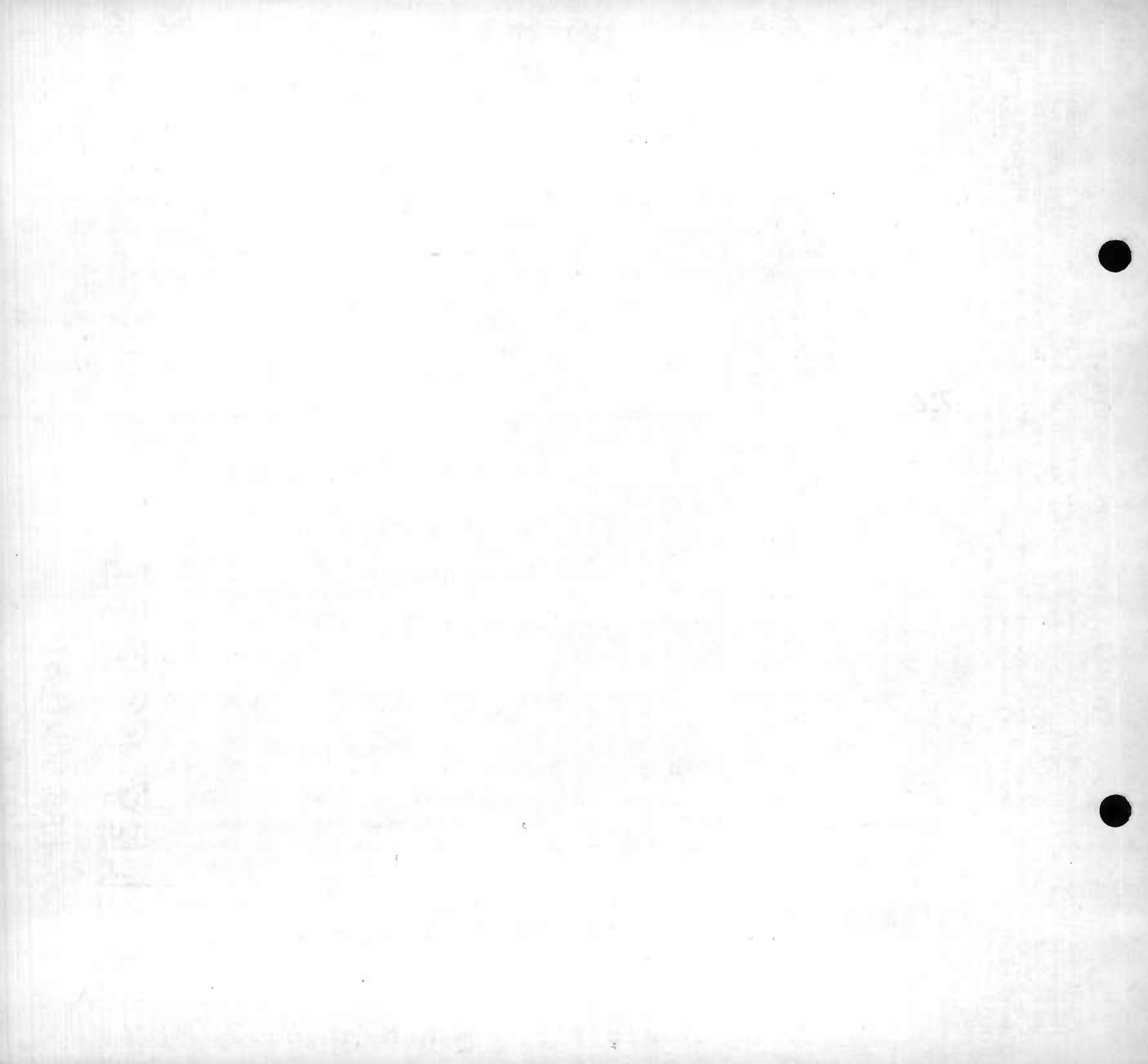
STATEVILLE NC

JOSEPH KNIGHT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 2689					CERTIFICATE OF DEATH					Registered No. 65 2689				
1. NAME OF DECEASED (Type or Print) <b>CARRETHERS, JOHNNIE</b>										2. DATE AND HOUR OF DEATH <b>March 7, 1965 11:50 P M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Joseph Hospital</b>										4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-04</b>				
5. SEX <b>Male</b> 6. RACE <b>Colored</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never married</b>										8. DATE OF BIRTH <b>7-20-20</b>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>										11. BIRTHPLACE (State or foreign country) <b>Georgia</b>				
10B. KIND OF BUSINESS OR INDUSTRY										12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>CRAWFORD CARRETHERS</b>										14. MOTHER'S MARDEN NAME <b>SARAH UPSON - COX</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>										16. SOCIAL SECURITY NO. <b>242-05-0543</b>				
17. INFORMANT <b>me. Walton</b>										ADDRESS <b>915 Bonaparte st</b>				
18. <b>165X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic carcinoma of lung</b>										INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Malnutrition &amp; dehydration</b>														
19A. DATE OF OPERATION <b>0</b>										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) <b>No</b>										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)										21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from <b>March 6, 1965</b> to <b>March 7, 1965</b> , that (I) (we) lost saw the deceased olive on <b>March 7, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.														
23A. SIGNATURE 										23B. DATE SIGNED <b>3-7-65</b>				
23C. PHYSICIAN'S NAME (Type) <b>T.P. ANTONY</b>										23D. ADDRESS <b>1400 N. Caroline Street- 21213</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>										24B. DATE				
24C. NAME of CEMETERY or CREMATORY										24D. LOCATION (City, town, or county) (State) <b>WINSTON-SALEM N.C.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>										25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>				
25C. FUNERAL DIRECTOR <b>JOSEPH-KNIGHT</b>										ADDRESS <b>1639 N BROADWAY</b>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2690</u>	
BIRTH NO. <u>65 2690</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Margaret Anna Cairns</u>		2. DATE AND HOUR OF DEATH <u>March 10, 1965</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <u>4000 Primrose Avenue</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-19</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4000 Primrose Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 21, 1892</u>	9. AGE (In years lost birthday) <u>72 Yrs.</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dress Ship Mgr.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>August Manns</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Kommalan</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-8742</u>		17. INFORMANT ADDRESS <u>Miles Berger - 216 W. Madison Street</u>	
18. <u>133.8</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Carcinoma of Colon</u> DUE TO (B) DUE TO (C) 		INTERVAL BETWEEN ONSET AND DEATH <u>14 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>January</u> 19 <u>61</u> to <u>March 10</u> 19 <u>65</u> , that (I) ( <u>X</u> ) last saw the deceased alive on <u>March 10</u> 19 <u>65</u> and that in (my) ( <u>X</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>W</u> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Julius C. Gluck</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>3/11/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Julius C. Gluck</u>				23D. ADDRESS <u>5356 Reisterstown Road</u> <u>Baltimore, Maryland</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/13/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 12 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Staley</u>		25C. FUNERAL DIRECTOR <u>Ellsworth Armacost</u> <u>Ellsworth Armacost-4600 Liberty Hghts. Ave</u>			

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1  
F-160

65 2691

BALTIMORE CITY HEALTH DEPARTMENT

65 2691

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BERNARD G. PFEIFER

2. DATE AND HOUR PRONOUNCED DEAD

March 9, 1965 12:39 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

White Marsh

D. STREET ADDRESS (If rural, give location)

Loreley Beach Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

6/29/19

9. AGE (In years  
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

George J. Pfeifer

14. MOTHER'S MAIDEN NAME

Barbara Cora Diepolo

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

212-18-8550

17. INFORMANT

(mother)

ADDRESS

Barbara Pfeifer Loreley Beach Road, White

18.

CAUSE OF DEATH

March, Maryland

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐

NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED  
3/10/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/13/65

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 12 1965

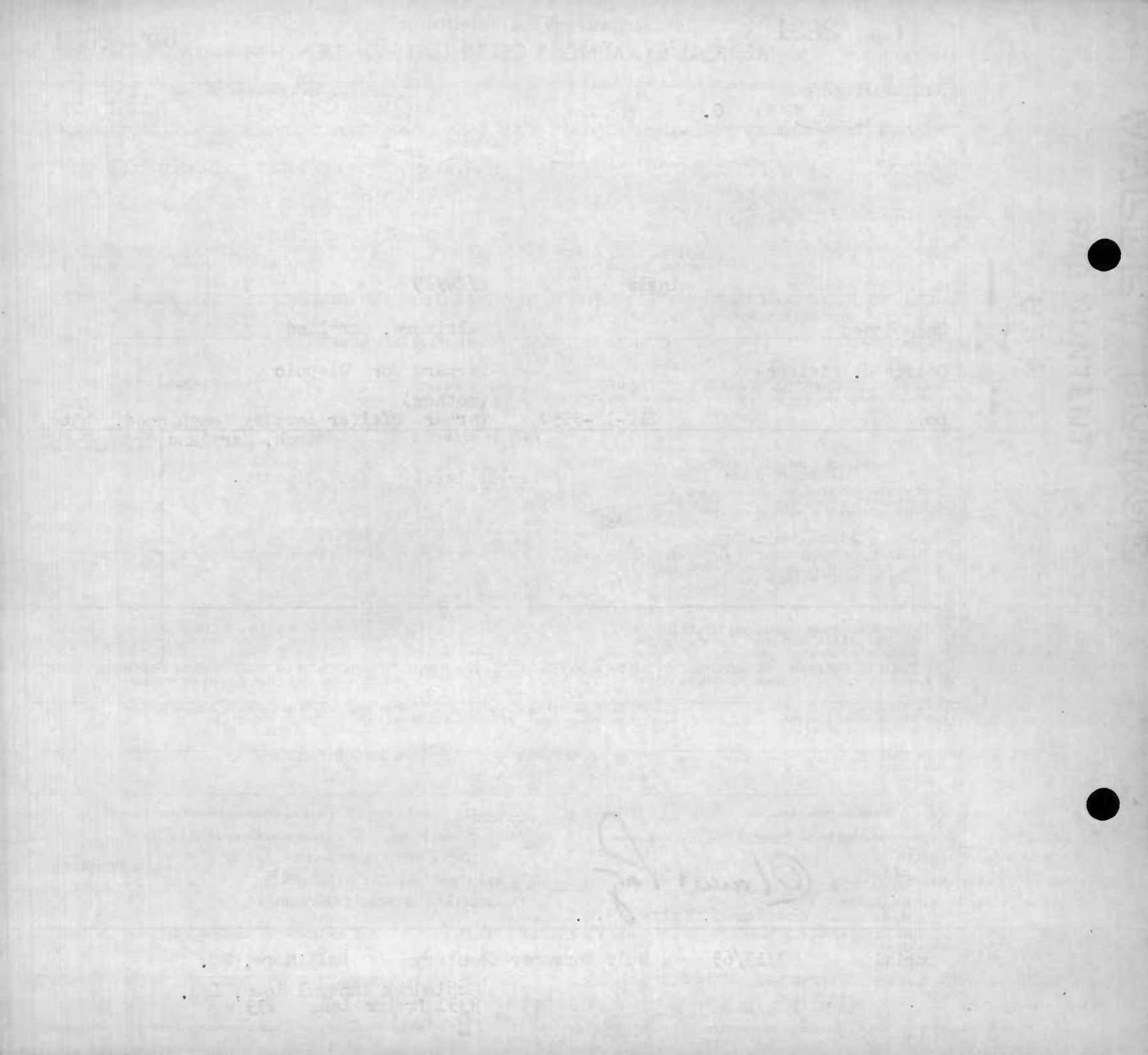
24B. NAME OF REGISTRAR

Robert E. Petty M.D.

24C. FUNERAL DIRECTOR

Schlimmer Funeral Home, Inc.  
3331 Brehms Lane #13

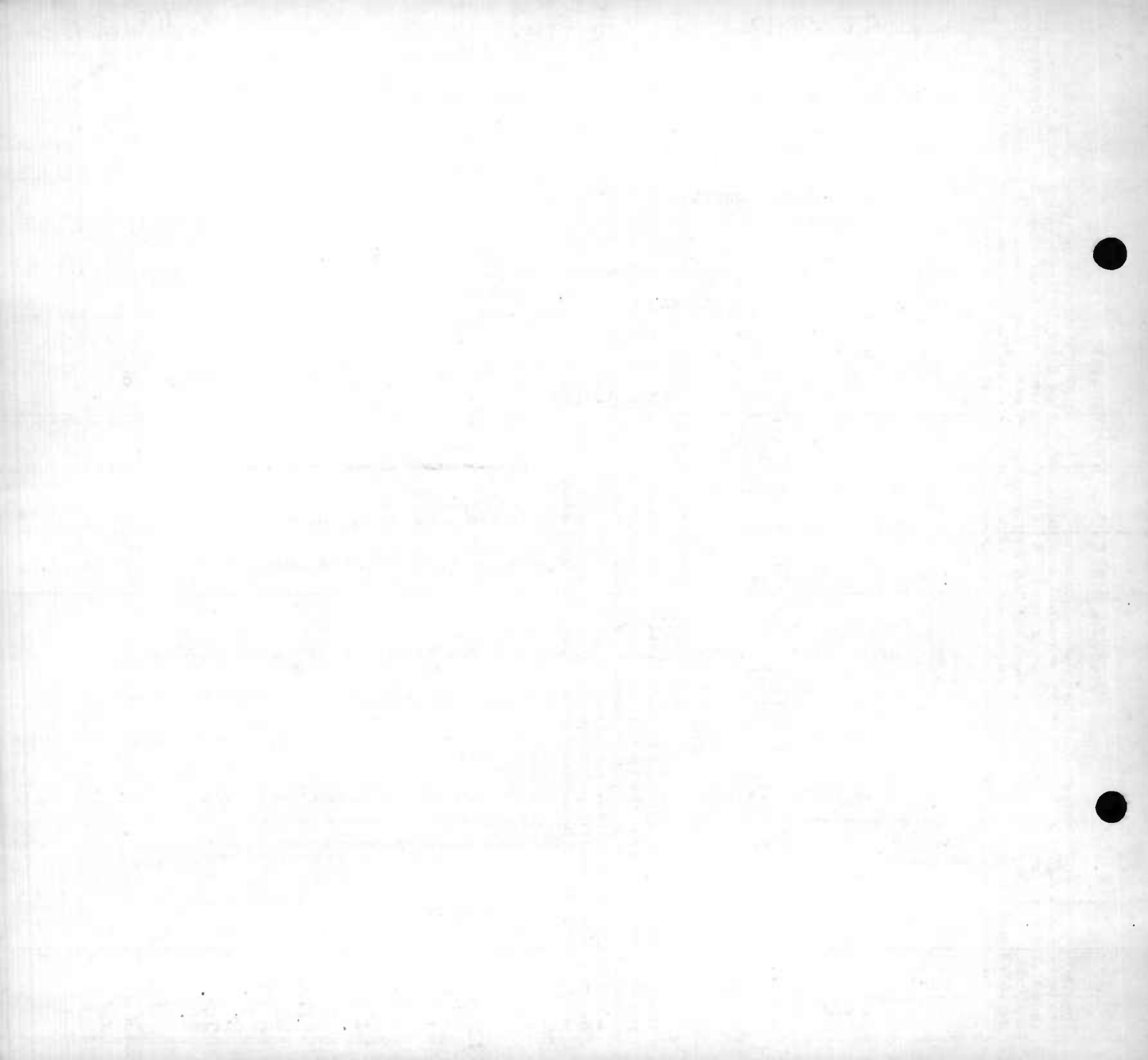
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

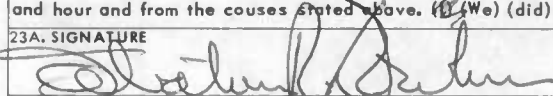
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

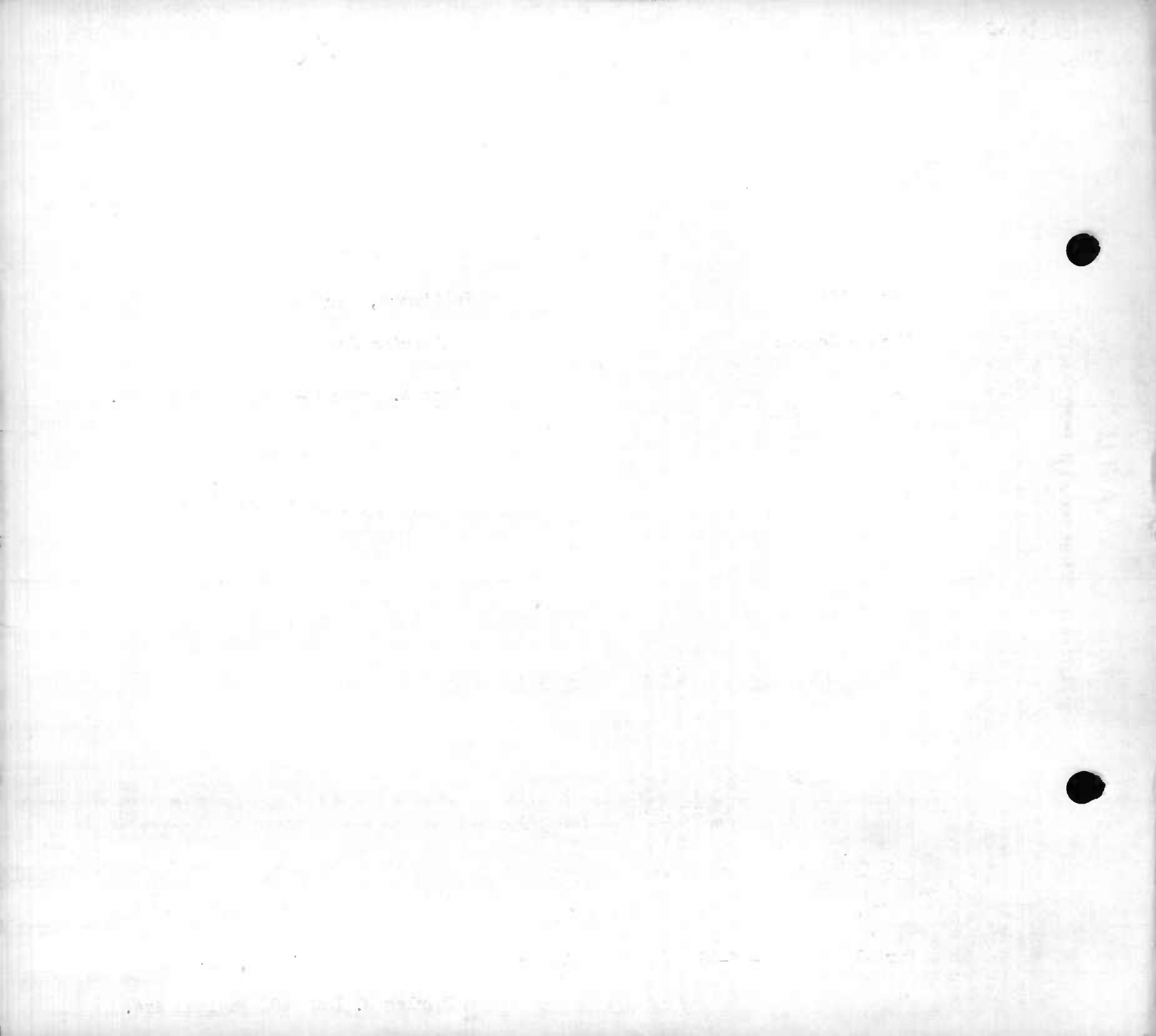
BIRTH NO. <b>65 2692</b>		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. <b>65 2692</b>	
1. NAME OF DECEASED (Type or Print) <b>BECKER, CARL</b>			2. DATE AND HOUR OF DEATH <b>March 10, 1965 5:05 P.M.</b>		
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2602</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secures Hospital</b> (If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>4243 SHAMROCK AVE # 6</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <b>12-16-86</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Esskay</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
13. FATHER'S NAME <b>Karl Becker</b>			14. MOTHER'S MAIDEN NAME <b>DOROTHEA LINBERG</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-03-9117</b>		17. INFORMANT <b>HEING K BECKER - SON</b> Address <b>4243 Shamrock Avenue #6</b>	
18. <b>722.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>Coronary Heart Failure</b> DUE TO (B) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (C) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>years</b> <b>years</b>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>February 11, 1965</b> to <b>March 10, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 10, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>ZENAIDA G. PALAD</b>				23B. DATE SIGNED <b>March 10, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>ZENAIDA G. PALAD</b>		23D. ADDRESS <b>BON SECOURS HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/13/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>		25B. NAME OF REGISTRAR <b>Robert S. Taylor</b>		25C. FUNERAL DIRECTOR <b>Schlimmer Funeral Home, Inc.</b> Address <b>2601-03-05 E. Madison Street #5</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 2693	
<b>BIRTH NO.</b> 65 2693 <b>CERTIFICATE OF DEATH</b>					
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>MAE PAULINE PORTER</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>3-10-65 10:00 A.M.</b>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MERCY HOSPITAL</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Middle River, Md.</b> D. STREET ADDRESS (If rural, give location) <b>1200 JACKSON AVE 5300</b>		
<b>5. SEX</b> <b>F</b>	<b>6. RACE</b> <b>C</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</b> <b>WIDOW</b>	<b>8. DATE OF BIRTH</b> <b>5-11-1896</b>	<b>9. AGE (In years last birthday)</b> <b>68</b>	<b>10. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>		
<b>13. FATHER'S NAME</b> <b>Thomas Jordan</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Catherine Jones</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Simon A. Porter - 3511 Ellamont Rd.</b>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>CAUSE OF DEATH</b> (A) <b>Ventricular Fibrillation</b> DUE TO <b>Proved by EKG</b> (B) <b>ASCVD with Congestive</b> DUE TO <b>Heart failure</b> (C)		
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>Diabetes Mellitus</b>		
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>YES</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (this hospital) attended the deceased from 3-4 1965 to 3-10 1965, that (we) last saw the deceased alive on 3-10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b>  <b>23C. PHYSICIAN'S NAME (Type)</b> <b>Salvatore R. Donohue</b>				<b>23B. DATE SIGNED</b> <b>3-10-65</b>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>3-15-65</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>New Cathedral</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>MAR 12 1965</b>		<b>25B. NAME OF REGISTRAR</b> <b>Charles R. Law</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Charles R. Law</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b>		<b>24E. ADDRESS</b> <b>802 Madison Ave.</b>			

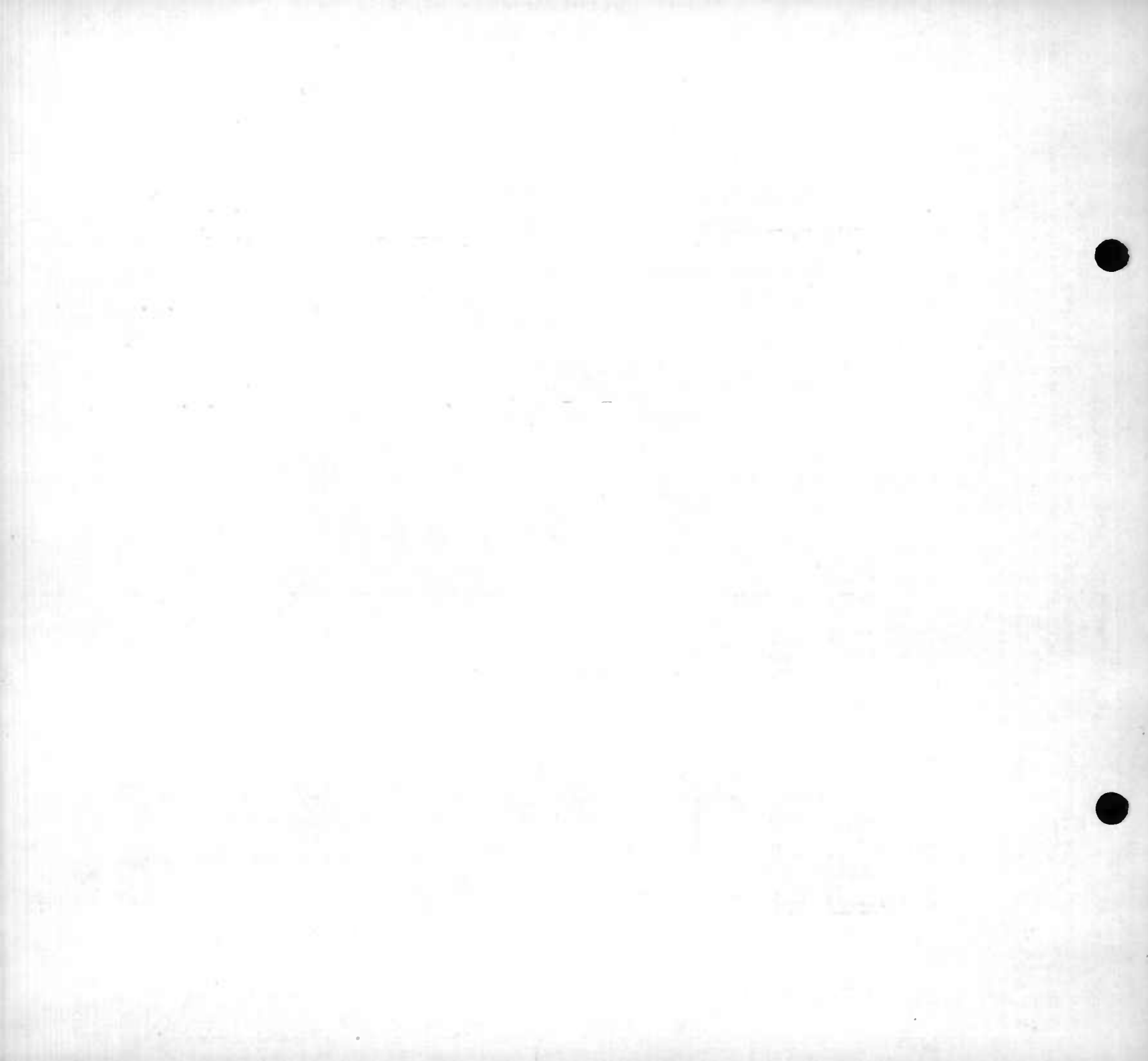


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2694		CERTIFICATE OF DEATH		Registered No. 65 2694	
1. NAME OF DECEASED (Type or Print) <b>William Emmitt Stokes</b>				2. DATE AND HOUR OF DEATH <b>March 8, 1965</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital 1514 Division St</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY <b>District of Columbia</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Washington</b> D. STREET ADDRESS (If rural, give location) <b>3219 Sherman Ave N.W.</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Nov 30, 1872</b>		9. AGE (In years last birthday) <b>92</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>		11. BIRTHPLACE (State or foreign country) <b>Denwittie Co, Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13. FATHER'S NAME <b>Emanuel Stokes</b>				14. MOTHER'S MAIDEN NAME <b>Susan Bonner</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-62-9262</b>		17. INFORMANT <b>Mrs. Elizabeth Mack N.W. Wash, DC</b>					
18. <b>420.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Heart Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Gangrene Left Foot</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b> <b>3 mo</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>12-9</b> 19 <b>64</b> to <b>3-8</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3-8-64</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>G. Franklin Phillips</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/11/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>G. Franklin Phillips</b>				23D. ADDRESS <b>558 No. Nelson St. Balt. Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/13/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Mount Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Staley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Robert E. Staley</b>		ADDRESS <b>3035 W. North Ave</b>			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES

C.

WALLACE

2. DATE AND HOUR PRONOUNCED DEAD

March 11, 1965

9:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1641 E. North Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Sept. 1885

9. AGE (In years  
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Lawyer - self employed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Charles Wallace

14. MOTHER'S MAIDEN NAME

Priscilla Renshaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mercy Hospital Records

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
(If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/11/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/13/1965

23C. NAME of CEMETERY or CREMATORY

Greenmount Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 12 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Johnson &amp; Sons

ADDRESS

Baltimore, Md. 21217

North 1st Avenue

VALLEY FORGE

PAID

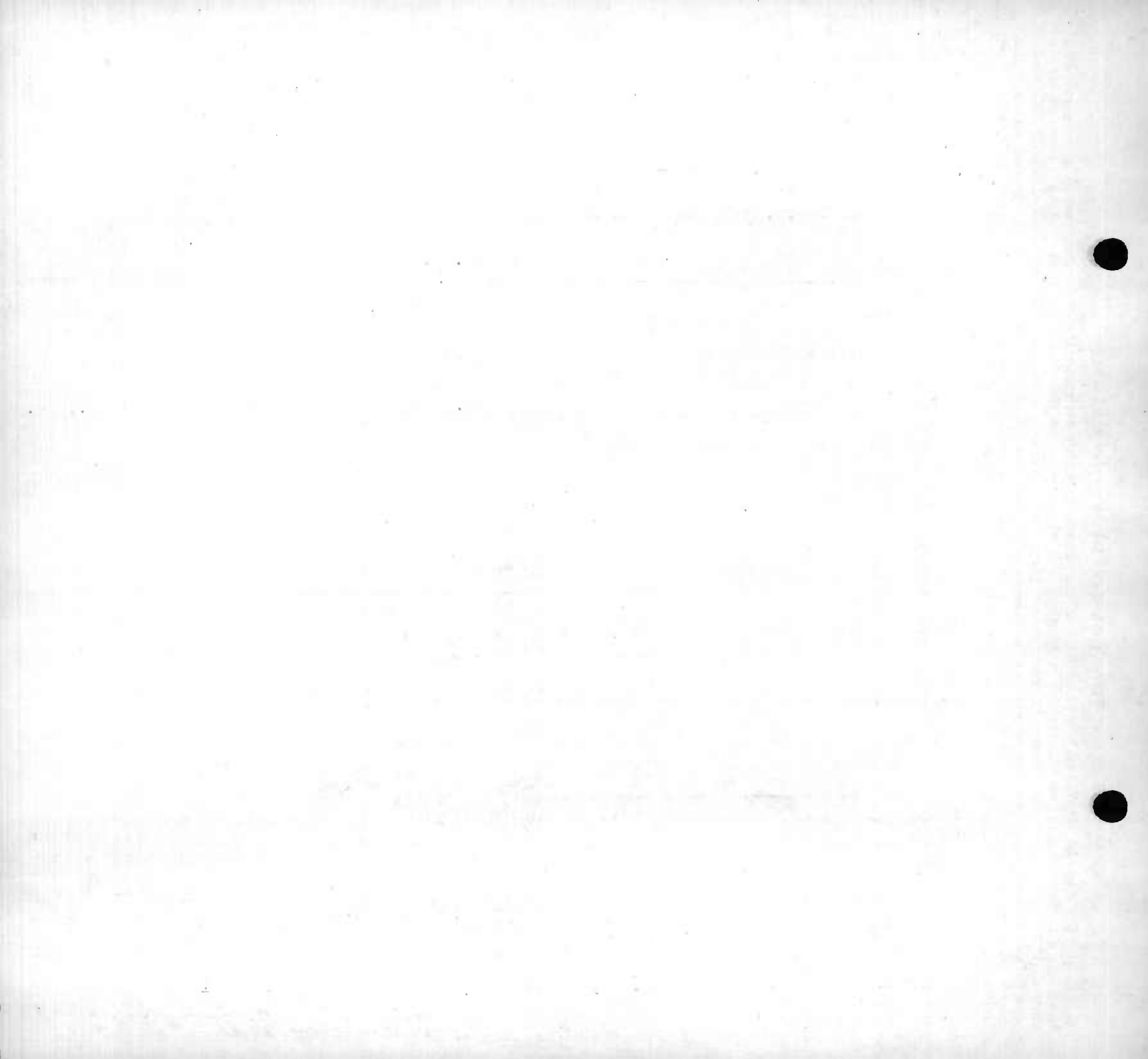
1861

Glenn J. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		65 2696		65 2696	
BIRTH NO. 65 2696		CERTIFICATE OF DEATH		Registered No. 65 2696	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Marylee Wright		2. DATE AND HOUR OF DEATH March 10, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Middle River 63-00	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines - Belvedere 2525 West Belvedere Avenue Baltimore, Maryland 21215		D. STREET ADDRESS (If rural, give location) 72 Fenway South 20			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 7, 1888	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenville, Texas	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME James Gehagan Matthews		14. MOTHER'S MAIDEN NAME Ida Brown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Mary Upton Route 16 Box 452 Balto., Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Broncho-pneumonia (B) Arterio-sclerotic Heart Disease (C) Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 5 days - 10 yrs. 2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arterio-sclerosis					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Jan - 1950 to March 10 1965, that (I) last saw the deceased alive on March 10 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
23A. SIGNATURE Earl L. Chambers		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/12/65	
23C. PHYSICIAN'S NAME (Type) Earl L. Chambers		23D. ADDRESS 4108 Bluff Hts. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/13/1965		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. MAR 12 1965		24F. NAME OF REGISTRAR Robert E. Stacey	
24G. FUNERAL DIRECTOR Wm. J. Tidwell & Sons		24H. ADDRESS Baltimore, Md. 21217		24I. NORTH - Pa. Ave.	



*M. 352* *65 2697* **BALTIMORE CITY HEALTH DEPARTMENT** *65 2697*

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
HARRY MITTNACHT		March 9, 1965 8:30 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  Franklin Square Hospital		A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore <i>1802</i> D. STREET ADDRESS (If rural, give location) 21 N. Carey Street	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH April 27, 1906
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper		10B. KIND OF BUSINESS OR INDUSTRY Brewery	9. AGE (In years last birthday) 58
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME Benjamin A. Mittnacht		14. MOTHER'S MAIDEN NAME Ida Zerrlaut	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 213-14-9013	
17. INFORMANT Mrs. Etta Grimstead		ADDRESS 3523 Oakmont Ave. Baltimore, Md.	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  Disseminated Lupus Erythematosus. (A) DUE TO _____ (B) DUE TO _____ (C) DUE TO _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 3/10/65			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 3/15/1965	23C. NAME of CEMETERY or CREMATORY Baltimore National	23D. LOCATION (City, town, or county) (State) Baltimore, Maryland
24A. DATE REC'D BY HEALTH DEPT. MAR 12 1965	24B. NAME OF REGISTRAR Robert E. Gentry, M.D.	24C. FUNERAL DIRECTOR Wm. J. Johnson & Sons Baltimore, Md. 17 North L Pa. Ave	

VS 151-REV. 1/1/65

WALLEY FOLGE

HASPOONTIV

Class 12



BIRTH NO.

65 2698

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 2698

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE H. ARMSTRONG

2. DATE AND HOUR PRONOUNCED DEAD

March 10, 1965 6:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

644 N. Carey Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

W

8. DATE OF BIRTH

Mar. 23, 1899

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Writer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Elizabeth City, N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

217-01-5810

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/11/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3-13-1965

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

Bolto.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 12 1965

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

C. D. Wilson

ADDRESS

1000 Brantley Ave

WILEY

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

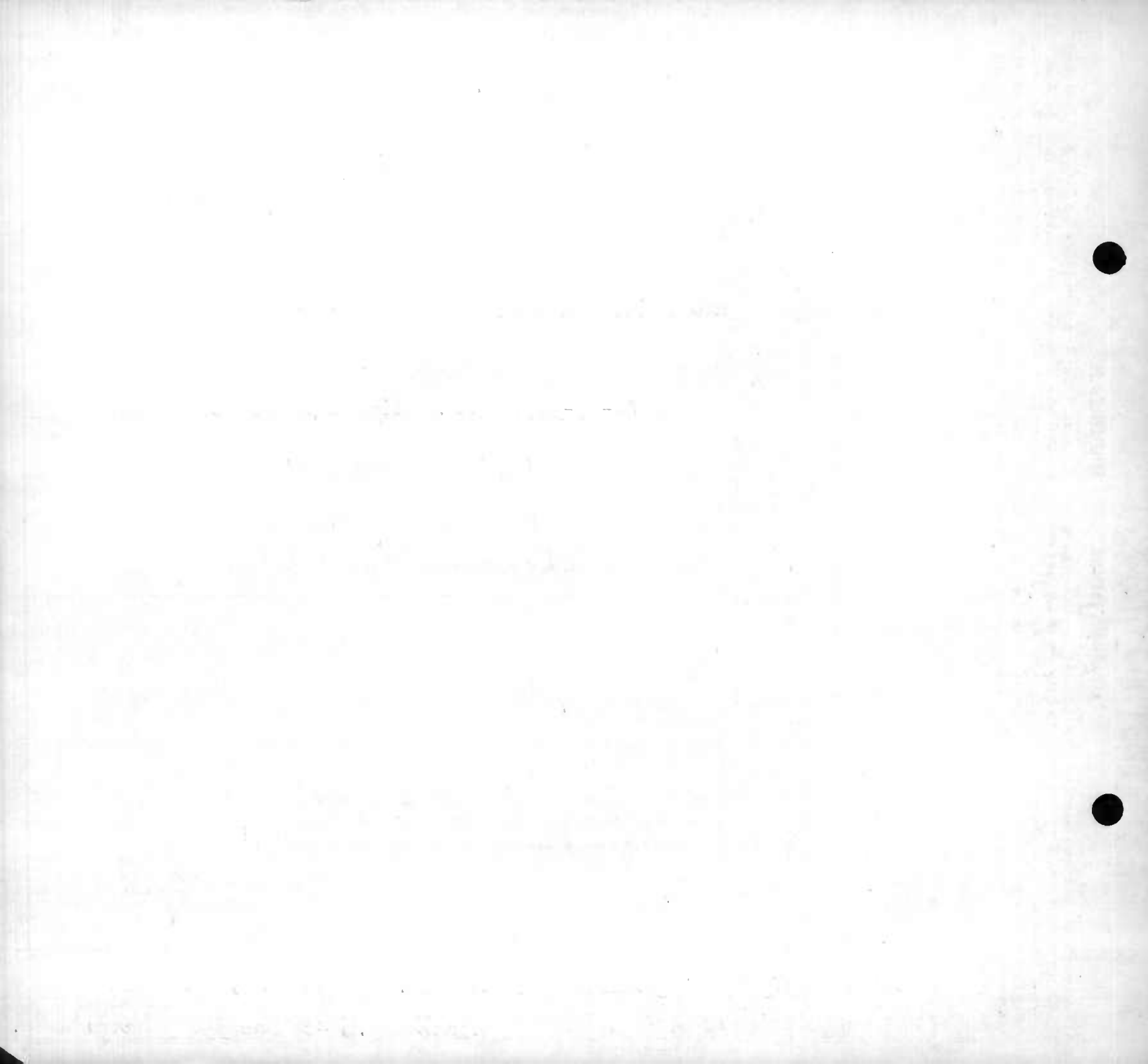
B-653				65 2699		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2699	
BIRTH NO.				M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>DELMA BRYANT</b>				2. DATE AND HOUR OF DEATH <b>3/10/65 5:45 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>				A. STATE <b>Md.</b>		8. COUNTY <b>Balto.</b>		75-33	
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 39 md.</b>					
				D. STREET ADDRESS (If rural, give location) <b>2510 Hollins Ferry Road</b>					
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>		8. DATE OF BIRTH <b>4/17/05</b>	9. AGE (In years lost birthday) <b>59</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William G. Lyle</b>				14. MOTHER'S MAIDEN NAME <b>Berta M. Stoen</b>					
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Luther Williams</b>		ADDRESS <b>same</b>	
18. <b>420.14-260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Embolus (?)</b>				CAUSE OF DEATH (A) DUE TO <b>Complicating Myocardial Infarction</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 hr -</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>arteriosclerotic heart disease</b>				(B) DUE TO <b>Diabetic Acidosis</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>2/28/65</b> 19 <b>65</b> to <b>3/10</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3/10</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Francine Paritta</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <b>3/10/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Francine Paritta</b> M.D.						23D. ADDRESS <b>University Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-15-1965</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Carver Park</b>		24D. LOCATION (City, town, or county) (State) <b>Lanham Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Edith Williams / Mrs. Brantley</b>		ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 2700	
BIRTH NO. 65 2700		CERTIFICATE OF DEATH									
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Jackson, Andrew B.						2. DATE AND HOUR OF DEATH March 11, 1965 6:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Balto						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 5370			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital		D. STREET ADDRESS (If rural, give location) 343 St. Georges Rd #2									
5. SEX Male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 2/3/1880		9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Balto. Md	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Automobile Salesman		11. BIRTHPLACE (State or foreign country) Balto. Md		12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME Andrew Jackson				14. MOTHER'S MAIDEN NAME Anna Falk							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. 218-09-3044		17. INFORMANT Mrs. Elizabeth Gaegler		ADDRESS same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 420.1-153.3		CAUSE OF DEATH (A) Myocardial infarction (B) ASCVD (C) Carcinoma, Sigmoid Colon						INTERVAL BETWEEN ONSET AND DEATH 3 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Partial		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from March 4, 1965 to March 11, 1965, that (I) (we) last saw the deceased alive on March 11, 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Yim, pill sun M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED March 11, 1965			
23C. PHYSICIAN'S NAME (Type) Yim, pill sun M.D.				23D. ADDRESS Maryland General Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/65		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem.		24D. LOCATION (City, town, or county) (Note) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 12 1965		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS 530 5 Harford Rd.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2701		CERTIFICATE OF DEATH		Registered No. 65 2701	
1. NAME OF DECEASED (Type or Print) <i>William A. Foreman, Sr.</i>				2. DATE AND HOUR OF DEATH <i>March 11, 1965</i> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-48</i>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>6005 Clearspring Road</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>					
				D. STREET ADDRESS (If rural, give location) <i>6005 Clearspring Road</i>					
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>9-23-1881</i>	9. AGE (in years last birthday) <i>83</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Contractor and Builder</i>			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>George Foreman</i>				14. MOTHER'S MAIDEN NAME <i>Emma Veronica King</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Charles W. Foreman</i>			
				ADDRESS <i>711 Cedarcroft Rd.</i>					
18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Hypertensive Cardio-Vascular Dis - 10 YRS</i> DUE TO (B) <i>Arteriosclerosis -</i> DUE TO (C) <i>10 YRS.</i>				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>11-23-58</i> to <i>3-11-65</i> , that (I) (we) last saw the deceased alive on <i>3-10-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Anthony F. Carozza</i> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>3-12-65</i>		
23C. PHYSICIAN'S NAME (Print) <i>Anthony F. Carozza</i> M.D.				23D. ADDRESS <i>5217 York Rd Baito 12 Md</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>3-15-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Mary's Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 12 1965</i>		25B. NAME OF REGISTRAR <i>R. E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i>		ADDRESS <i>Baltimore, Md.</i>			



1. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

2. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

3. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

4. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

5. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

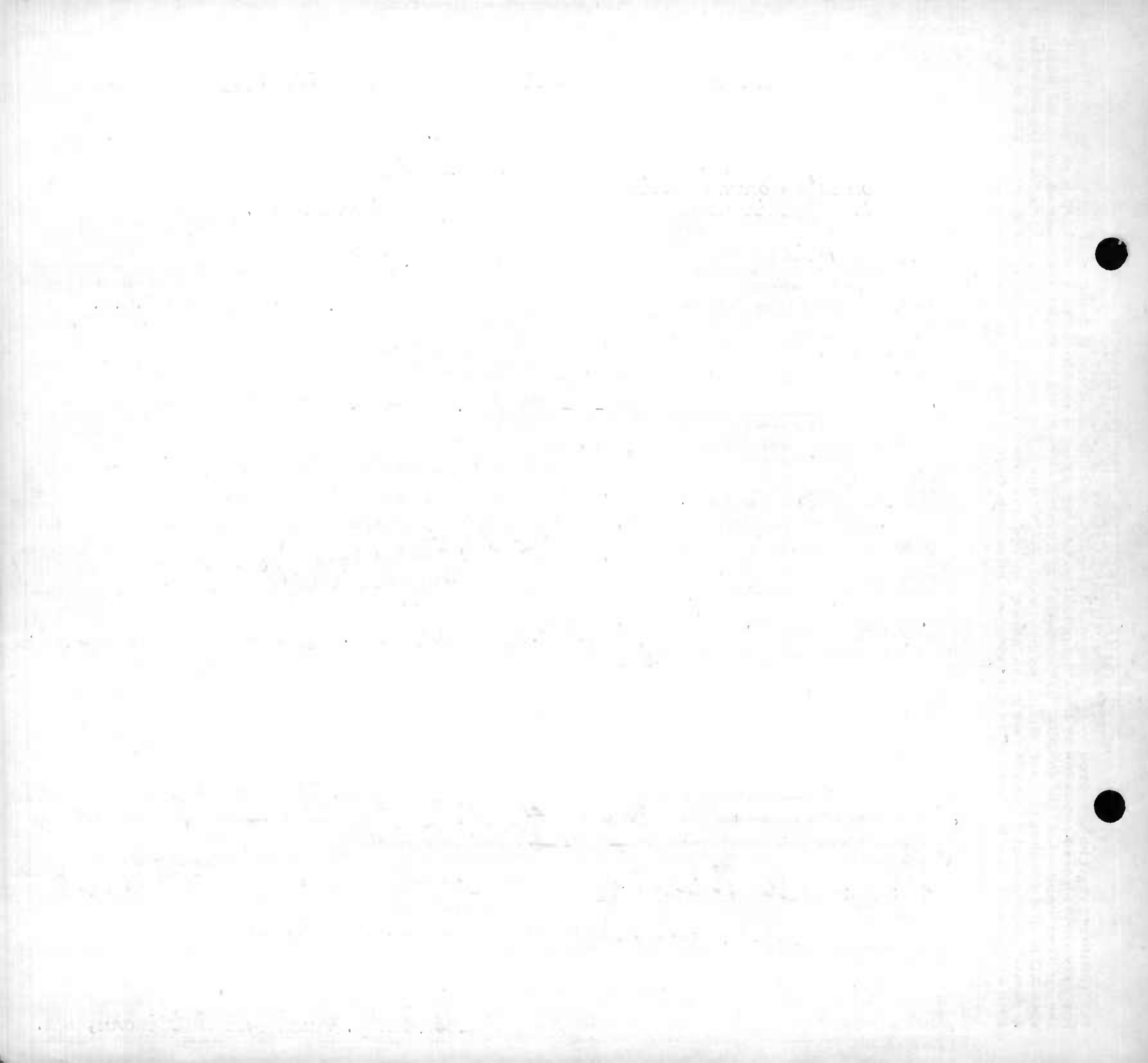
6. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

7. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2702		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 65 2702	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) Andrew Selig		2. DATE AND HOUR OF DEATH March 11, 1965 6:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould's Convalesorium 6116 Belair Road		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) Parkville 5300 D. STREET ADDRESS (If rural, give location) 2906 Linwood Ave.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH June 20, 1876	9. AGE (In years last birthday) 88	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Building Supply		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Selig		14. MOTHER'S MAIDEN NAME Anna Lind	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-44-0791		17. INFORMANT Mr. Andrew L. Selig 2906 Linwood Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: 430.01 + 159X ANTECEDENT CAUSES: II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH: Atherosclerotic Heart Disease Coronary atherosclerosis Myocardial infarction - Anterior wall Obstructive pulmonary disease - primary Site undetermined OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Pernicious Anemia, Paget's Disease, Bone		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 15, 1958 to Mar 11, 1965, that (I) (we) last saw the deceased alive on Mar 4, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald W. Mintzer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/12/65	
23C. PHYSICIAN'S NAME (Type) Donald W. Mintzer		23D. ADDRESS 3009 Evergreen Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/65		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Baltimore, Maryland		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 12 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR PL 2ndrd J. Ruck Inc Baltimore, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2703		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2703	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>KAY, WALTER HAROLD, Sr.</b>			<b>MARCH 10, 1965 6 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>			A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Seithucina 52-00</b>		
			D. STREET ADDRESS (If rural, give location) <b>100 Patricia Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	B. DATE OF BIRTH <b>12/18/93</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Racing Com.</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry Levi Kay</b>		14. MOTHER'S MAIDEN NAME <b>Lola (Unknown)</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>216-07-7492</b>		17. INFORMANT <b>Mrs. Pauline Kay (Wife)</b>	
18. <b>420.1 I</b>		CAUSE OF DEATH		ADDRESS <b>Hospital Records Same As #4</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Acute myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Arteriosclerotic heart disease</b>			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 6 1965</b> to <b>March 10 1965</b> , that (I) (we) last saw the deceased alive on <b>March 10 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Barry N. Rosenbaum</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>March 10, 1965</b>
23C. PHYSICIAN'S NAME (Type) <b>Barry N. Rosenbaum</b>			23D. ADDRESS <b>University Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>March 13, 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Johns Cem.</b>	
24D. LOCATION <b>Ellicott City, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>		24F. NAME OF REGISTRAR <b>Robert E. Stalks, M.D.</b>	
24G. FUNERAL DIRECTOR <b>RV-2 S. S. Sington</b>		24H. ADDRESS <b>Glen Burnie, Md.</b>			

3

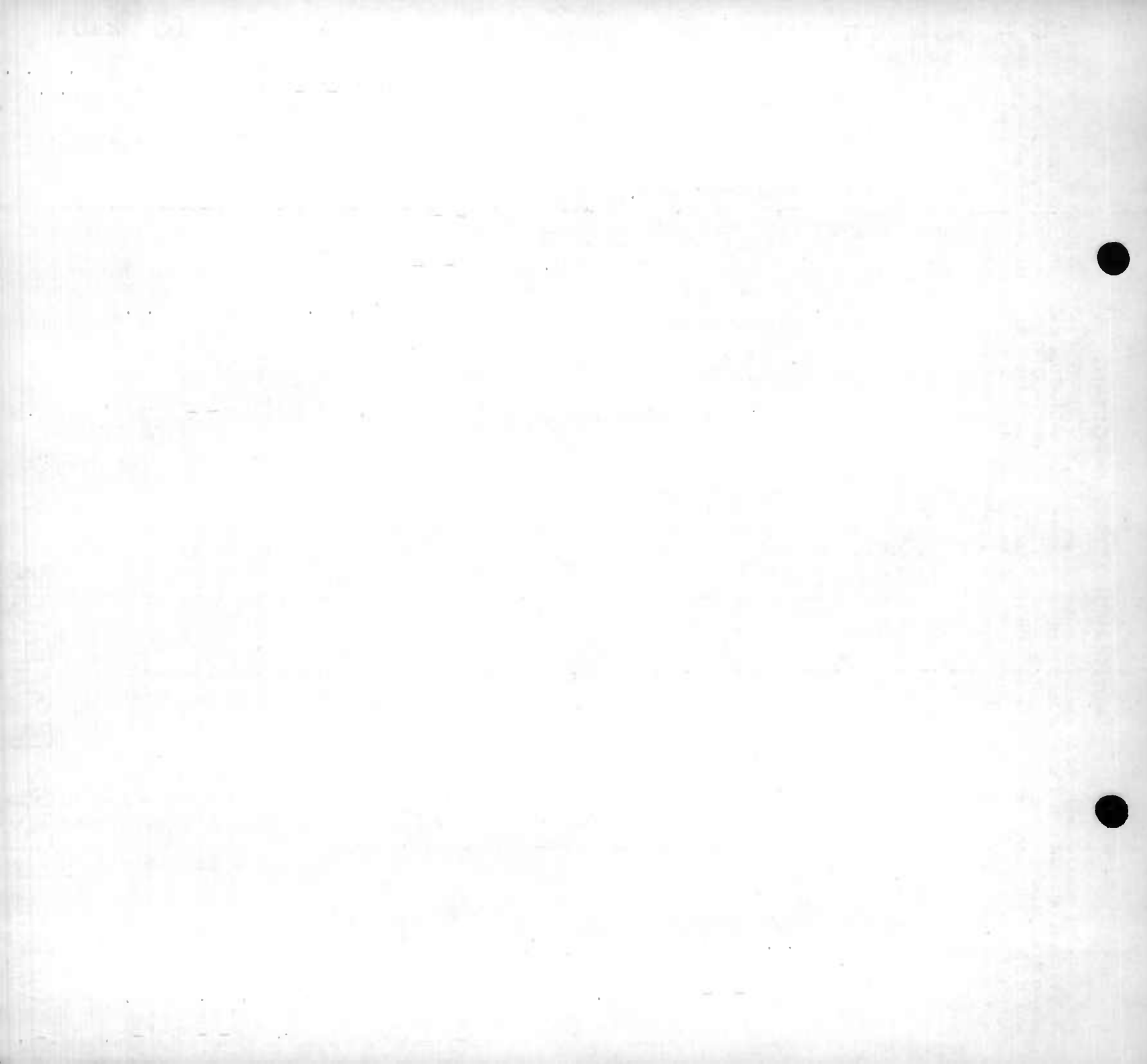
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <span style="font-size: 1.5em;">65 2704</span>		REGISTERED NO. <span style="font-size: 1.5em;">65 2704</span>	
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">MISS MARGARET MOTTU</span>				<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">MARCH-12-1965 13:15 3.15 A.M.</span>			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <span style="font-size: 1.2em;">(died at her residence.)</span> </div> <div> <b>(If not in hospital or institution, give street address or location)</b> </div> </div>				<b>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</b> <b>A. STATE</b> <span style="font-size: 1.2em;">Maryland</span> <b>B. COUNTY</b> <span style="font-size: 1.2em;">Baltimore City</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span> <b>6. RACE</b> <span style="font-size: 1.2em;">White</span> <b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</b> <span style="font-size: 1.2em;">Never Married.</span>				<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Sept-29-1885</span> <b>9. AGE (In years lost birthday)</b> <span style="font-size: 1.2em;">79</span>			
<b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <span style="font-size: 1.2em;">none</span>				<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">none</span>		<b>11. BIRTHPLACE (State or foreign country)</b> <span style="font-size: 1.2em;">Baltimore, Md.</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.</span>				<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Thomas H. Mottu</span>			
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Ellen Sewell</span>				<b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <span style="font-size: 1.2em;">no</span>			
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">no</span>				<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Miss Mottu, (sister)</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">106-W-University Pky. 10</span>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>CAUSE OF DEATH</b> <span style="font-size: 1.5em;">Cancer of Ovary</span>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.5em;">4 months</span>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>							
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b> <input type="checkbox"/>		<b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">1951</span> <b>to</b> <span style="font-size: 1.2em;">March 12 1965</span> , <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">March 11 1965</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">W. G. Helfrich</span>				<b>M.D. Attending Phys.</b> <input checked="" type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input type="checkbox"/>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3-12-65</span>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.2em;">Wm. G. Helfrich</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">5006 Roland Ave</span>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">March-15-65</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">London Park</span>		<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md. 21220</span>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">MAR 12 1965</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">R. E. Galt</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Stewart M. McEn Co. 106-W-North-Av. City-1</span>			

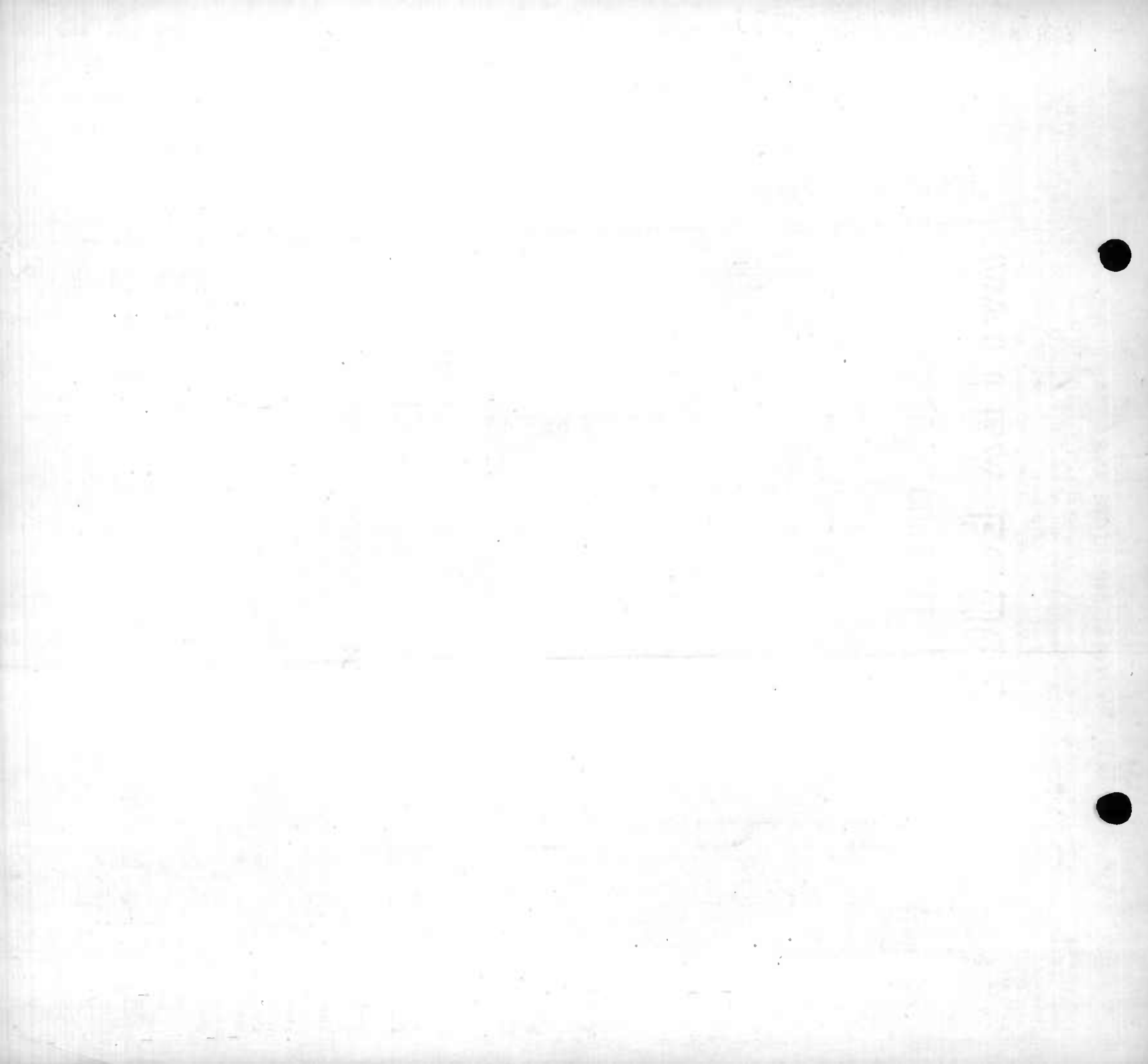




# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2705		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2705	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) LEW, YUK		2. DATE AND HOUR OF DEATH 3-10-65- 9 <sup>30</sup> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MARYLAND			
		D. STREET ADDRESS (If rural, give location) 13 GRIFFON R.D., Crofton Rd			
5. SEX MALE	6. RACE ORIENTAL	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10-10-95	9. AGE (In years lost birthday) 69	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) CHINA	
13. FATHER'S NAME WAH LEW.		14. MOTHER'S MAIDEN NAME TOM FUNG.		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Albert Sew (nephew) 12-Crafton Rd. (21221)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 177X I		CAUSE OF DEATH (A) DUE TO Interstate Co. of products (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) X	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 3/8/65 19 to 3/10/65 19, that (X) (we) last saw the deceased alive on 3/10/65 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Calhoun		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/10/65	
23C. PHYSICIAN'S NAME (Type) DR. R. CALHOUN.		M.D. 23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE March-17-65		24C. NAME of CEMETERY or CREMATORY Lorraine	
24D. LOCATION Woodlawn		24E. BALTIMORE ADDRESS 21207		24F. CITY, TOWN, OR COUNTY BALTIMORE	
25A. DATE REC'D BY HEALTH DEPT. MAR 12 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Stewart 2 Mowen Co. 108-W North Av. City 1	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

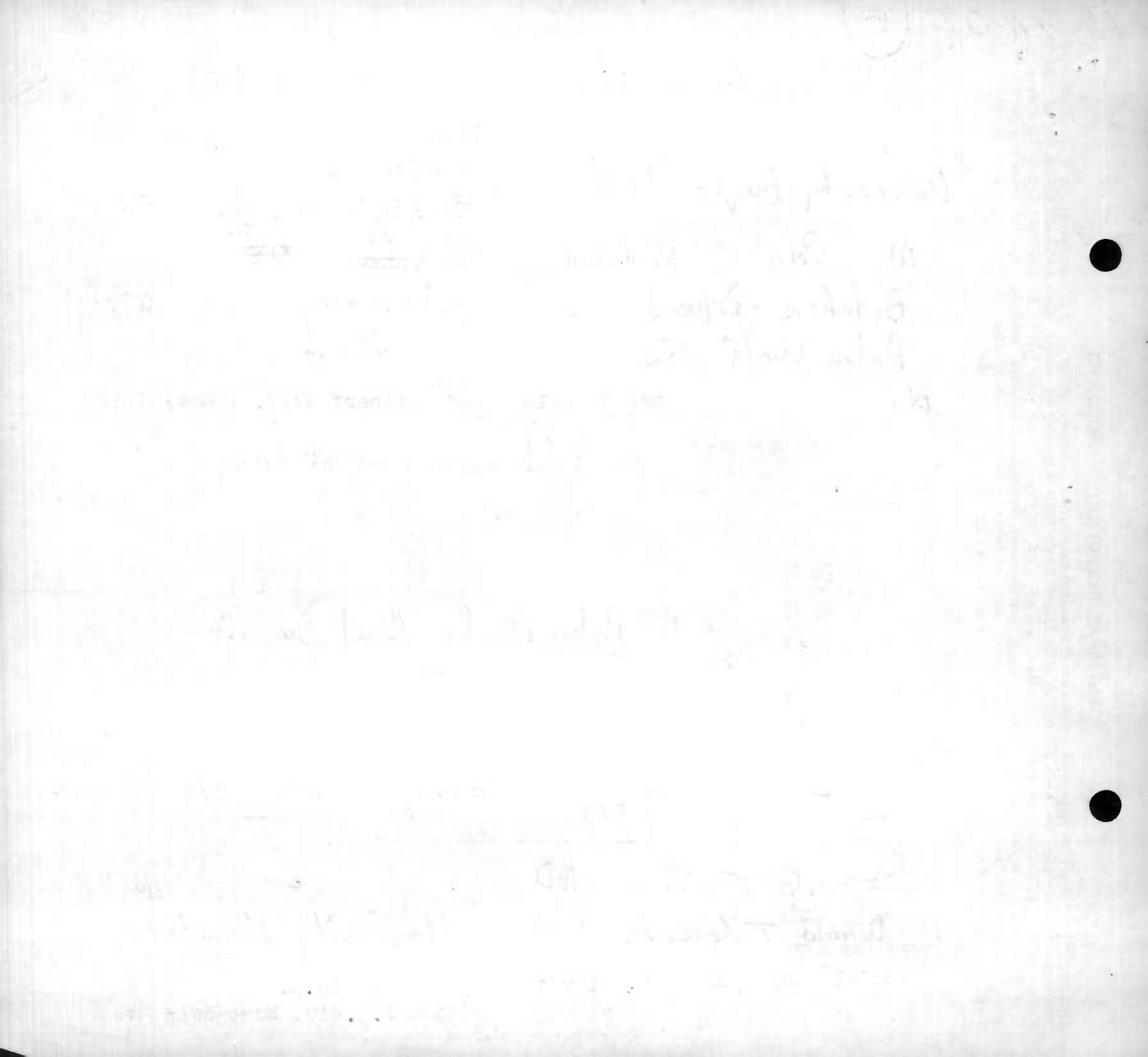
BIRTH NO. <b>285 2706</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2706</b>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Annie E. Beck</b>		2. DATE AND HOUR OF DEATH <b>March 9/65</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>28-04</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Hood's Nursing Home</b> <b>5313 Edmondson Ave</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <del>5313</del> <b>405 A Edsdale Rd</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>Single</b>	8. DATE OF BIRTH <b>Feb. 15, 1874</b>	9. AGE (In years last birthday) <b>91</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John A. Beck</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Beck</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Edna H. Leanann, 405 A. Edsdale Rd. zone 29</b>	
18. <b>181.0 I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Carcinomatosis</b> DUE TO		<b>6 mos.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Carcinoma of Bladder</b> DUE TO		<b>6 yrs.</b>	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 1961</b> 19 to <b>March 9</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>March 8</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Geo. E. Wells</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/10/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Geo. E. Wells</b>		23D. ADDRESS <b>4102 Edmondson Ave</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/12/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. 29, Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jankins</b>	
25C. FUNERAL DIRECTOR <b>Witzke, F.D.</b>		25D. ADDRESS <b>4101 Edmondson Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>(6) 65 2707</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 2707</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Wolf Anton John</b>		2. DATE AND HOUR OF DEATH <b>March 7 1965 7<sup>50</sup> P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hosp - Balt.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
5. SEX <b>M</b>		6. RACE <b>Can</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	
8. DATE OF BIRTH <b>9/13/1922</b>		9. AGE (In years, months, days) <b>42</b>		10. If Under 1 Yr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Anton Wolf Sr.</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>085 07 3318</b>	
17. INFORMANT <b>Son Albert Wolf, (Same Name)</b>		ADDRESS <b>Same</b>		18. CAUSE OF DEATH <b>Carcinoma of Rt Lung</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerotic Heart Disease</b>		20. INTERVAL BETWEEN ONSET AND DEATH <b>?</b>		21. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>2</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>Yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>2/22</b> 19 <b>65</b> to <b>3/7</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3/7</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald T. Lewers</b>		23B. DATE SIGNED <b>7 Mar 7 1965</b>		23C. PHYSICIAN'S NAME (Type) <b>Donald T. Lewers</b>	
23D. ADDRESS <b>University Hospital</b>		23E. FUNERAL DIRECTOR <b>Witzke F.D. 4101 Edmondson Ave</b>		23F. ADDRESS <b>Witzke F.D. 4101 Edmondson Ave</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/11/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet</b>	
24D. LOCATION <b>Balto. Md</b>		24E. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>		24F. NAME OF REGISTRAR <b>Witzke F.D. 4101 Edmondson Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2708</b>	
BIRTH NO. <b>(4) 65 2708</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>3/6/65 3:15 P.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>Gertrude R. Wheeler</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY <b>1608</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>700 Edgewood St</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>700 Edgewood St</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>married</b>	8. DATE OF BIRTH <b>12/22/91</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H. W.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (in years last birthday) <b>73</b>
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel Earling</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Hanson</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>James C. Wheeler, 700 Edgewood St</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>422.11x260x</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <b>Cerebral thrombosis</b> DUE TO <b>cerebral arteriosclerosis</b> (B) <b>arteriosclerotic cardio-</b> DUE TO <b>vascular disease</b> (C) <b>Diabetes Mellitus</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 19 58</b> to <b>March 6, 19 65</b> , that (I) <del>was</del> last saw the deceased alive on <b>March 6 19 65</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>We</del> (did) <del>did not</del> view the body after death.			
23A. SIGNATURE <b>Harry L. Knipp</b>		23B. DATE SIGNED <b>3-9-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>HARRY L. KNIPP</b>		23D. ADDRESS <b>4116 Edmondson Ave. Balt 29, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/11/65</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Staker, MD</b>	
25C. FUNERAL DIRECTOR <b>Wibbels</b>		25D. ADDRESS <b>4101 Edmondson Ave</b>	

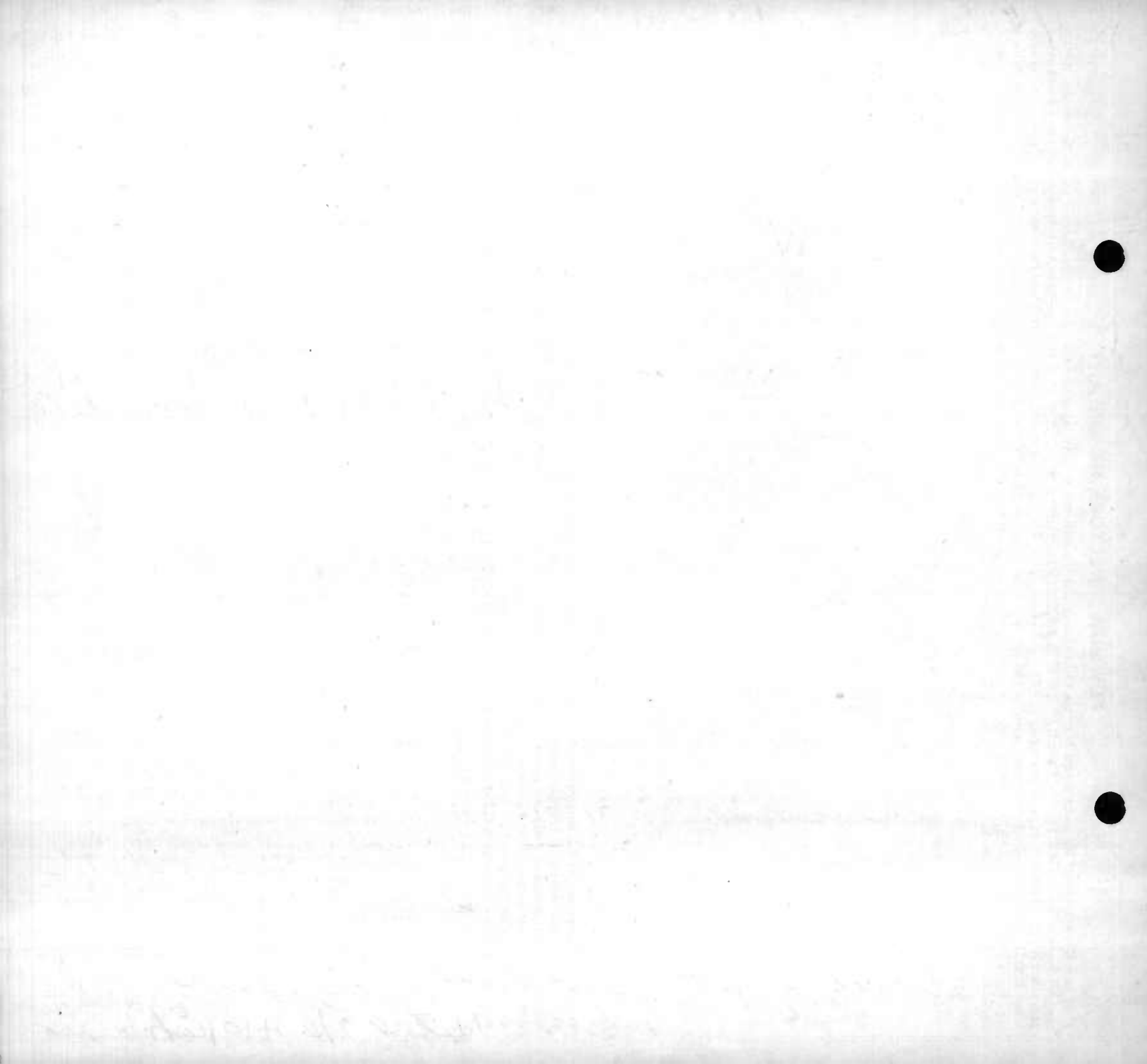




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-07356		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2709	
M.E. CASE NO.			1. NAME OF DECEASED		
(Type or Print)			BABY BOY KELLY		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			2. DATE AND HOUR OF DEATH		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address at location)			A. STATE		
BON SECOURS HOSPITAL			Maryland		
BALTIMORE, MD. 21223			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			1113 Haverhill Rd		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
MALE	W	WIDOWED, DIVORCED (specify)	3-10-65		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
		BALTIMORE, MD.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
WILLIAM T. KELLY			MAG DALENE PADREZAS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		
Wm. T. Kelly			1113 Haverhill Rd		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
773.5T			Cardiorespiratory insufficiency		
ANTECEDENT CAUSES			(A) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Immaturity		
			(B) DUE TO		
			Prematurity		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3/10/65 19 to 3/10/65 19 that (I) (we) last saw the deceased alive on 3/10/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
J. G. O'Connell			3/10/65		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/12/65		New Cathedral Balto. Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 12 1965		R. E. E. E. E.		W. B. E. E. E.	
				ADDRESS	
				410 Edmondson	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2710		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2710	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Julia Gisella Roberts</i>		2. DATE AND HOUR OF DEATH <i>March 11, 1965</i>		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <i>ST. AGNES Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>		D. STREET ADDRESS (If rural, give location) <i>2136 WILKENS AVE.</i>	
5. SEX <i>FEMALE</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>May 4, 1901</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sewing Machine Oper.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Slip Covers</i>		11. BIRTHPLACE (State or foreign country) <i>HUNGARY</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Hungary</i>		13. FATHER'S NAME <i>Michael Lukerich</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Sch Lind</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>215-03-6352</i>		17. INFORMANT ADDRESS <i>Katherine Hahn 2136 Wilkens Ave.</i>	
18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Hypertension - Cerebro-vascular disease</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8-1-60</i> 19 to <i>3-11-65</i> 19, that (I) (we) last saw the deceased alive on <i>3-1-65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Harry S. Gimbel</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3-12-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>HARRY S. GIMBEL</i>		23D. ADDRESS <i>4805 Edmonson Ave</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>3-13-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge</i>	
24D. LOCATION (City, town, or county) (State) <i>Howard County Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 12 1965</i>		25B. NAME OF REGISTRAR <i>Robert S. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Geo. C. Schuchab Funeral Home</i>		25D. ADDRESS <i>Proctor's Home 2101 Frederick Ave.</i>			

54

3/11/11

Chamber

100

Hand & Head  
Honey & Butter

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2711		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2711	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) Bunker, Harold H.		2. DATE AND HOUR OF DEATH 9 March 1965 1 20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Arnold D. STREET ADDRESS (If rural, give location) Box 32			
5. SEX Male	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-6-93	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well Driller		10B. KIND OF BUSINESS OR INDUSTRY ←	11. BIRTHPLACE (State or foreign country) Minn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Russell Bunker			14. MOTHER'S MAIDEN NAME Lillian William		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Florence M Bunker		ADDRESS #4
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Intracranial bleeding less than 1 hour DUE TO (B) Chronic Myelogenous leukemia - 2 years DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED White At <input type="checkbox"/> Nat White <input type="checkbox"/> Work At <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (this hospital) attended the deceased from 2-12 1965 to 9 March 1965, that (we) last saw the deceased alive on 9 March 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward J. Ruley, MD				23B. DATE SIGNED 9 March 1965	
23C. PHYSICIAN'S NAME (Type) Edward J. Ruley		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/12/1965		24C. NAME OF CEMETERY or CREMATORY Hsburry Cemetery	
24D. LOCATION Arnold		24E. (City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 12 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR John M. Taylor & Sons	
				ADDRESS Annapolis, Md.	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

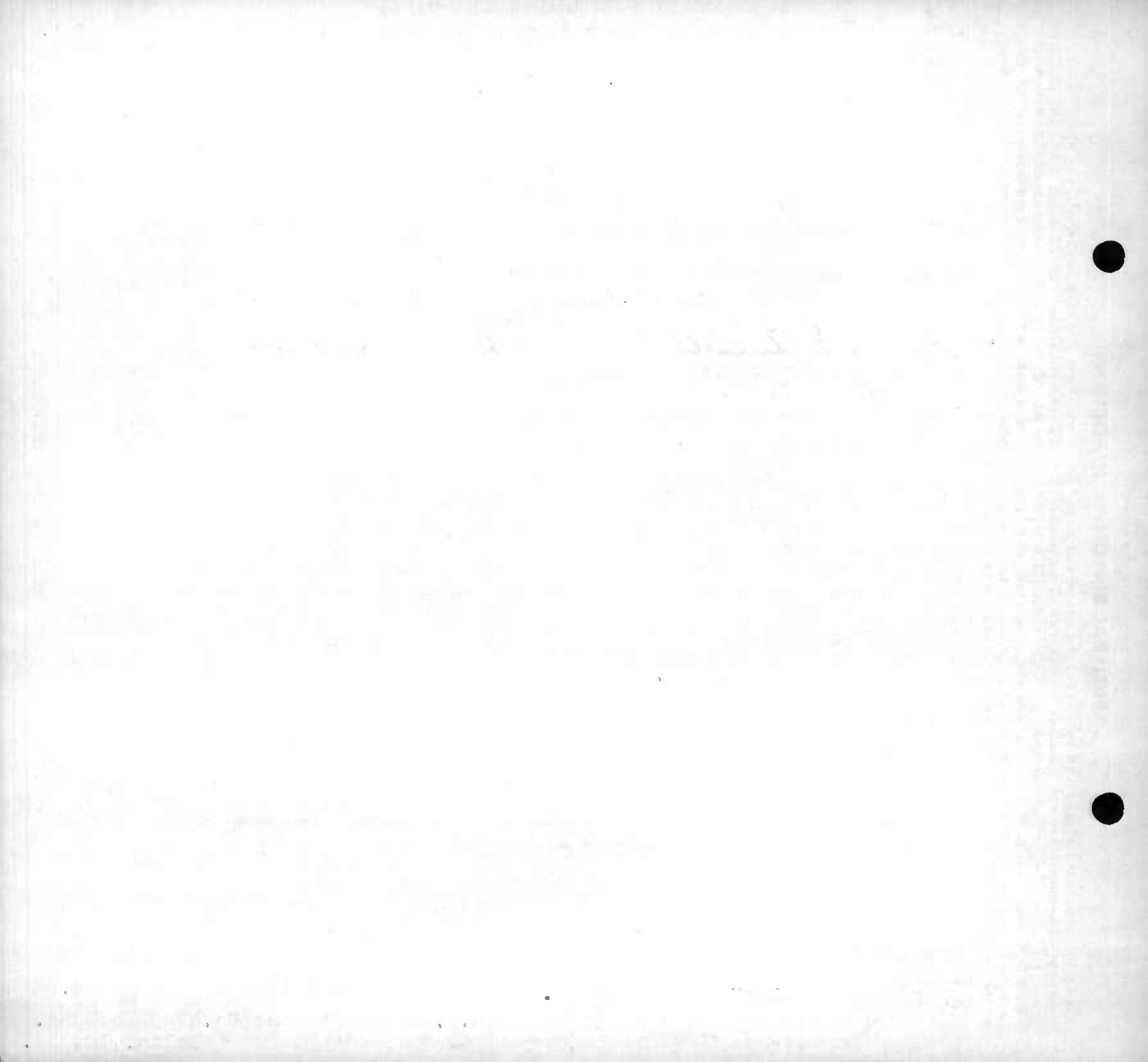
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2712</u>	
BIRTH NO. <u>65 2712</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>FRANCES Lee Bohn</u>			MARCH 10, 1965 1:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u> <u>BALTIMORE, MD</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>27-38</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		
			D. STREET ADDRESS (If rural, give location) <u>5713 CHINQUAPIN PKWAY</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11/26/07</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
13. FATHER'S NAME <u>George Hubbell</u>			12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>27-12-0987</u>		17. INFORMANT <u>CHARLES J. BOHN Sr.</u>
			ADDRESS <u>ABOVE</u>		
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO <u>Acute Myocardial infarction due to</u> (B) DUE TO <u>Recent occlusion of</u> (C) <u>left coronary artery</u>		
			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 10</u> 19 <u>65</u> to <u>MARCH 10</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>MARCH 10</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Union Memorial</u> M.A. Cohen				23B. DATE SIGNED <u>3/10/65</u>	
23C. PHYSICIAN'S NAME (Type) M.A. Cohen				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-13-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Baltimore Co.</u>	
24D. LOCATION (City, town, or county) (State) <u>Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 12 1965</u>			
25B. NAME OF REGISTRAR <u>H.W. Jenkins &amp; Sons Co.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

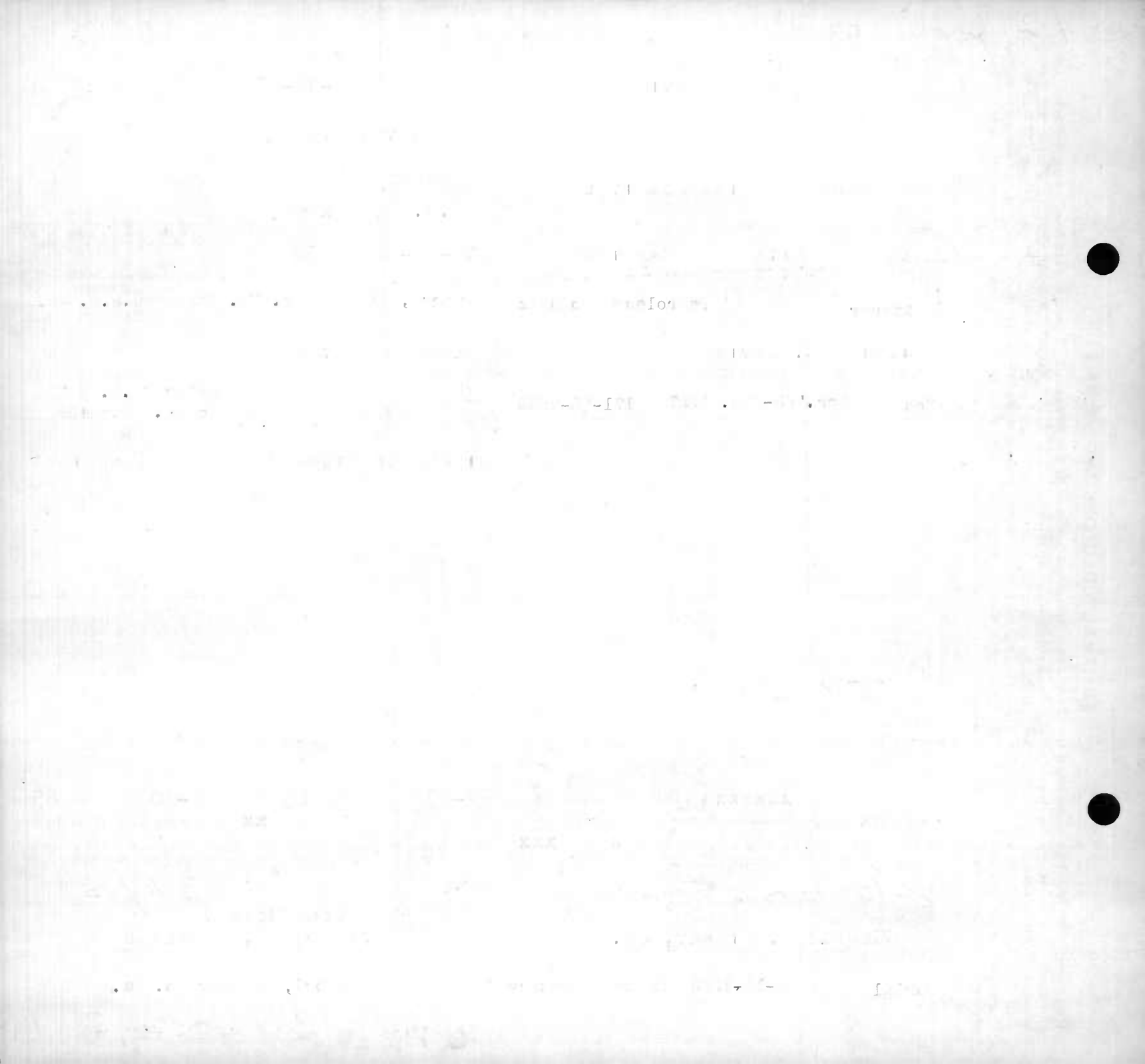
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 2713					CERTIFICATE OF DEATH					Registered No. 65 2713				
1. NAME OF DECEASED (Type or Print) <i>Hudson, Ethel R.</i>					2. DATE AND HOUR OF DEATH <i>3/11/65</i> <i>6:05 a.m.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore, Inc.</i>					(If not in hospital or institution, give street address or location)					A. STATE <i>Maryland</i>				
										B. COUNTY <i>27-10</i>				
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
										D. STREET ADDRESS (If rural, give location) <i>524 Padon ave</i>				
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>		8. DATE OF BIRTH <i>5/15/14</i>		9. AGE (In years last birthday) <i>50</i>		10. Under 1 Yr. Months: Oays: Hours: Min.		11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>OWN Home</i>					11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>				
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					13. FATHER'S NAME <i>Baschel J. Russell</i>					14. MOTHER'S MAIDEN NAME <i>Blanche Sparrow</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown NC</i>					16. SOCIAL SECURITY NO. <i>?</i>					17. INFORMANT <i>Hospital Record</i>				
18. <i>170X I</i>					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) <i>Carcinoma, O breast &amp; generalized metastases</i>					<i>3 yrs</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) OUE TO									
					(C) OUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										<i>None</i>				
19A. DATE OF OPERATION <i>2 1962</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma, O breast</i>			20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>10 March</i> 19 <i>65</i> to <i>11 March</i> 19 <i>65</i> , that <del>he</del> (we) last saw the deceased alive on <i>11 March</i> 19 <i>65</i> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> (We) (did) <del>(did not)</del> view the body after death.														
23A. SIGNATURE <i>Barry M. Cohen, M.D.</i>										23B. DATE SIGNED <i>3/11/65</i>				
23C. PHYSICIAN'S NAME (Type) <i>BARRY M. COHEN</i>										23D. ADDRESS <i>Sinai Hospital of Baltimore</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-15-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Parkwood</i>			24D. LOCATION (City, town, or county) (State) <i>Parkville Md.</i>							
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 12 1965</i>					25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>					25C. FUNERAL DIRECTOR <i>H.W. Jenkins &amp; Sons Co.</i>				
										ADDRESS <i>4905 York Rd. Balto., 12, Md.</i>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2714</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2714</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>HOWARD DAVIS</b>			2. DATE AND HOUR OF DEATH <b>3-10-65 11:05 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>PENNSYLVANIA</b> B. COUNTY <b>K-35</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>OXFORD</b> D. STREET ADDRESS (If rural, give location) <b>R.D. 2, Box 409</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>12-24-32</b>	9. AGE (In years last birthday) <b>32</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Petroleum Products</b>	11. BIRTHPLACE (State or foreign country) <b>Oxford, Chester Co. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>WILLIAM C. DAVIS</b>			14. MOTHER'S MAIDEN NAME <b>ELEANOR WALTON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes Apr.'55-Jan. 1957</b>		16. SOCIAL SECURITY NO. <b>171-26-2935</b>	17. INFORMANT ADDRESS <b>Frances J. Davis Oxford R.D. # 2 Penna. Box 409</b>		
1B. <b>15-IX-1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMA OF STOMACH</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>3 MONTHS</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>1 3-3-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TUMOR, ABDOMEN</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) <del>(XXXXXX)</del> attended the deceased from <b>2-19</b> 19 <b>65</b> to <b>3-10</b> 19 <b>65</b> , that (1) <del>(XX)</del> last saw the deceased alive on <b>3-9</b> 19 <b>65</b> and that in (my) <del>(XXX)</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>(XX)</del> (did) <del>(XXX)</del> view the body after death.					
23A. SIGNATURE <b>George G. Finney, Jr.</b> M.D.				23B. DATE SIGNED <b>3/10/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>GEORGE G. FINNEY, JR.</b> M.D.		23D. ADDRESS <b>5820 YORK ROAD BALTIMORE 12, MARYLAND</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3-13-1965</b>	24C. NAME OF CEMETERY or CREMATORY <b>Oxford Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Oxford, Chester Co. Pa.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 12 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Estep</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Frederick L. Goodie Rising Sun, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 2715	
BIRTH NO. 65 2715				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) ALLEN, ROBERT				2. DATE AND HOUR OF DEATH MARCH 11, 1965 18:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY BALTIMORE 22-02	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 30.			
				D. STREET ADDRESS (If rural, give location) 645 DOVER STREET			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 3/17/20	9. AGE (In years last birthday) 44	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER, COOK			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ALABAMA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIE ALLEN (DECEASED)				14. MOTHER'S MAIDEN NAME ANNIE <del>PEOPLES</del> PEOPLES (DECEASED)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS DECEASED		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 203X I MULTIPLE MYELOMA DIFFUSE				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION FEB. 5, 1965			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SPINAL CORD COMPRESSION			20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from January 27, 1965 to March 11, 1965, that (X) (we) last saw the deceased alive on March 11, 1965 and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Ivan L. Butler						23B. DATE SIGNED March 11, 1965	
23C. PHYSICIAN'S NAME (Type) IVAN L. BUTLER			23D. ADDRESS M.D. MERCY HOSPITAL, BALTO. Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/13/65		24C. NAME OF CEMETERY or CREMATORY Mt Calvary		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1965			25B. NAME OF REGISTRAR Charles E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Canal St		

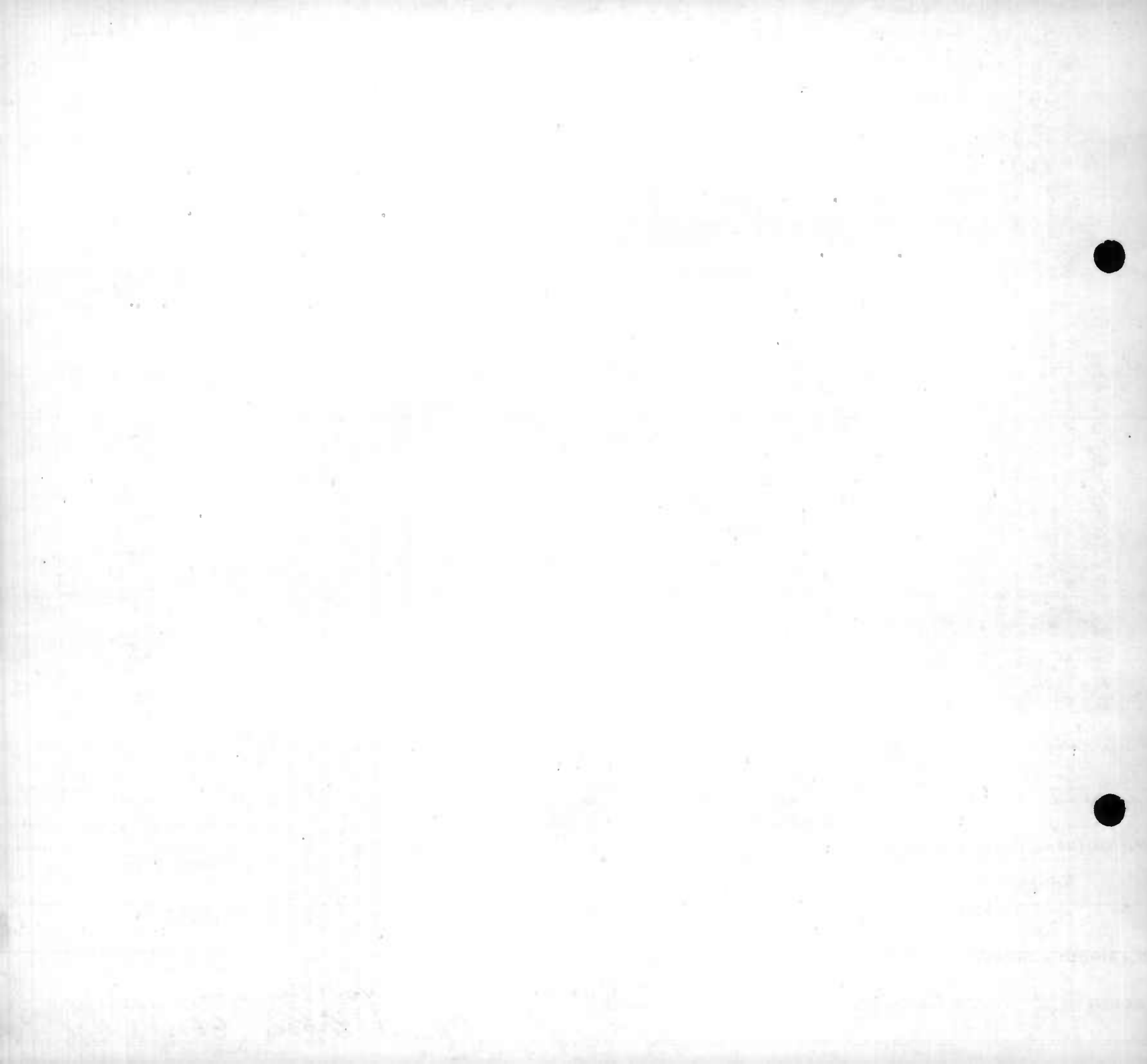




# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2716		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2716	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Daisey Green		2. DATE AND HOUR OF DEATH 3/12/65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2007		C. CITY OR TOWN (If outside city limits, write RURAL and give township), Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bar Wil Ba 2101 W. Cold Spring Lane		D. STREET ADDRESS (If rural, give location) 30 N. Monastery Ave.			
5. SEX F.	6. RACE C.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost high day) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records	
18. 42011 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Coronary Disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 342	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from June 10 1963 to Mar 12 1965, that (I) (we) last saw the deceased alive on Mar 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Louis A Johnson		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Mar 12-65	
23C. PHYSICIAN'S NAME (Type) Louis A Johnson		23D. ADDRESS 301-4-22-41, Balt 18th			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary	
24D. LOCATION (City, town, or county) (State) Baltimore md.		25A. DATE REC'D BY HEALTH DEPT. MAR 15 1965		25B. NAME OF REGISTRAR Robert E. Jarky	
25C. FUNERAL DIRECTOR Charles A Rice		ADDRESS 661 W. Borne St			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																								
BIRTH NO. <u>65 2717</u>					CERTIFICATE OF DEATH					Registered No. <u>65 2717</u>														
M.E. CASE NO. <u>DALEB</u>										1. NAME OF DECEASED (Type or Print) <u>Caleb William Wood JR</u>														
2. DATE AND HOUR OF DEATH <u>3/11/65</u>										9 40 P M.														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)														
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>										A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>														
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>										D. STREET ADDRESS (If rural, give location) <u>602 South Fulton Ave</u>														
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>sep.</u>		8. DATE OF BIRTH <u>6-7-02</u>		9. AGE (In years last birthday) <u>62</u>		11 Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.												
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>					12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME <u>CALEB WOOD</u>										14. MOTHER'S MAIDEN NAME <u>EFFIE</u>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <u>ALICE WOOD</u>					ADDRESS <u>1012 W. SARATOGA ST.</u>									
18. <u>143X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.										CAUSE OF DEATH (A) <u>Carcinoma of floor of mouth</u> DUE TO (B) _____ DUE TO (C) _____										INTERVAL BETWEEN ONSET AND DEATH <u>1 + yrs</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																								
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <u>No</u>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from <u>3/9/65</u> 19 to <u>3/11/65</u> 19, that (I) (we) last saw the deceased alive on <u>3/11/65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																								
23A. SIGNATURE <u>David W. Morse</u>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <u>3/12/65</u>									
23C. PHYSICIAN'S NAME (Type) <u>David W. Morse</u>										23D. ADDRESS <u>University Hospital</u>														
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>3-16-65</u>					24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn</u>					24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>									
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1965</u>					25B. NAME OF REGISTRAR <u>Robert E. Starnes</u>					25C. FUNERAL DIRECTOR ADDRESS <u>Charles R. Rice, 661 W. Barre St</u>														

1-18

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1-18

D-620

65 2718

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 2718

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

IDA DERRICK

2. DATE AND HOUR PRONOUNCED DEAD

3/11/65

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1350 Homestead St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1350 Homestead St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Widowed

8. DATE OF BIRTH

11/7/05

9. AGE (in years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Oays Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Lloyd Norris

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

217-34-6489

17. INFORMANT

ADDRESS

Ruth Stepney 342 East 25th St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic and hypertensive  
cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

W.U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

3/12/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/15/65

23C. NAME of CEMETERY or CREMATORY

St Thomas Cem.

23D. LOCATION

(City, town, or county)

Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

George A. Klem 1348 N. Calhoun St.

ADDRESS

VALLEY FORGE

THE CONTENT

Wm. M. Smith

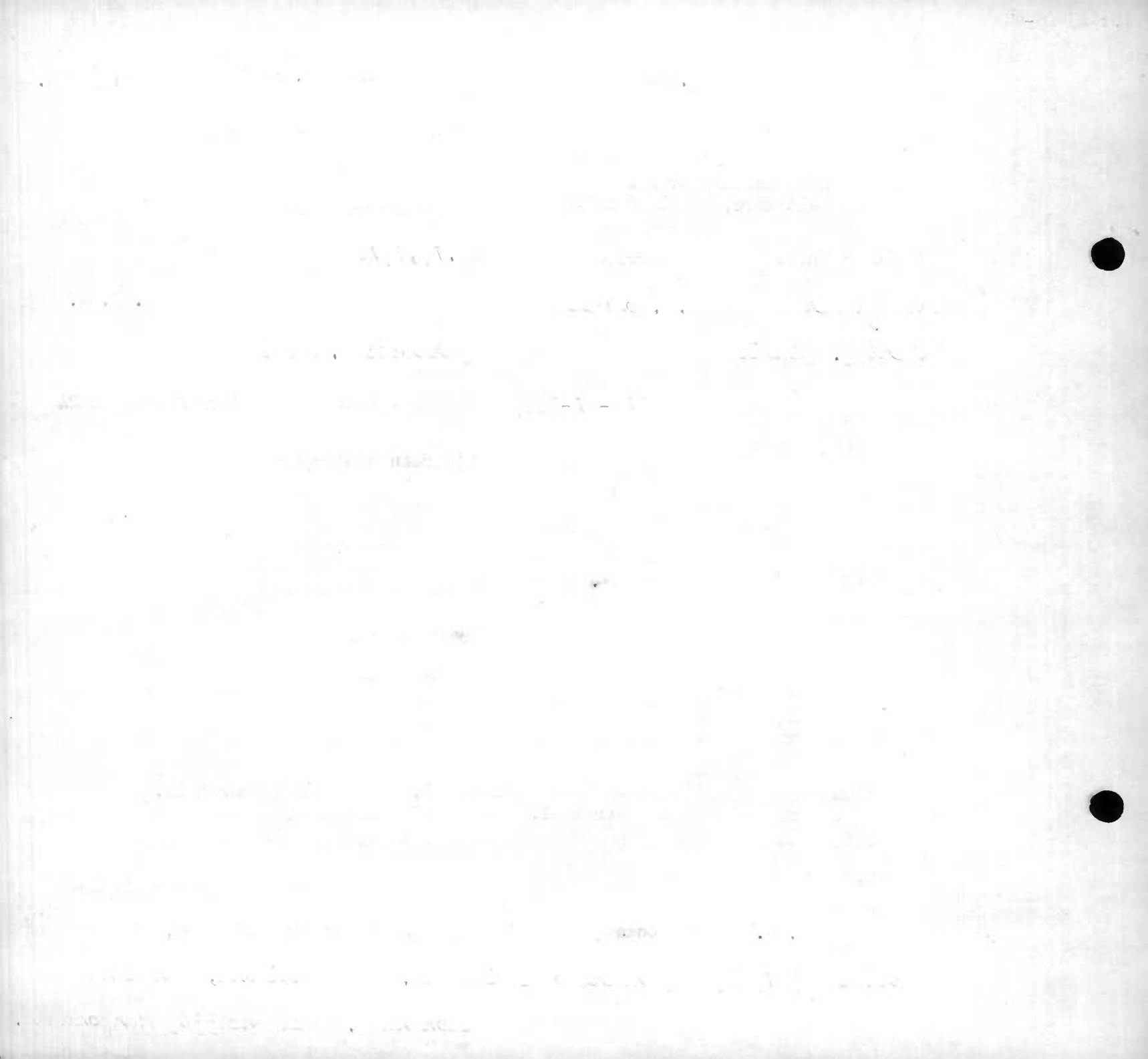
1841



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

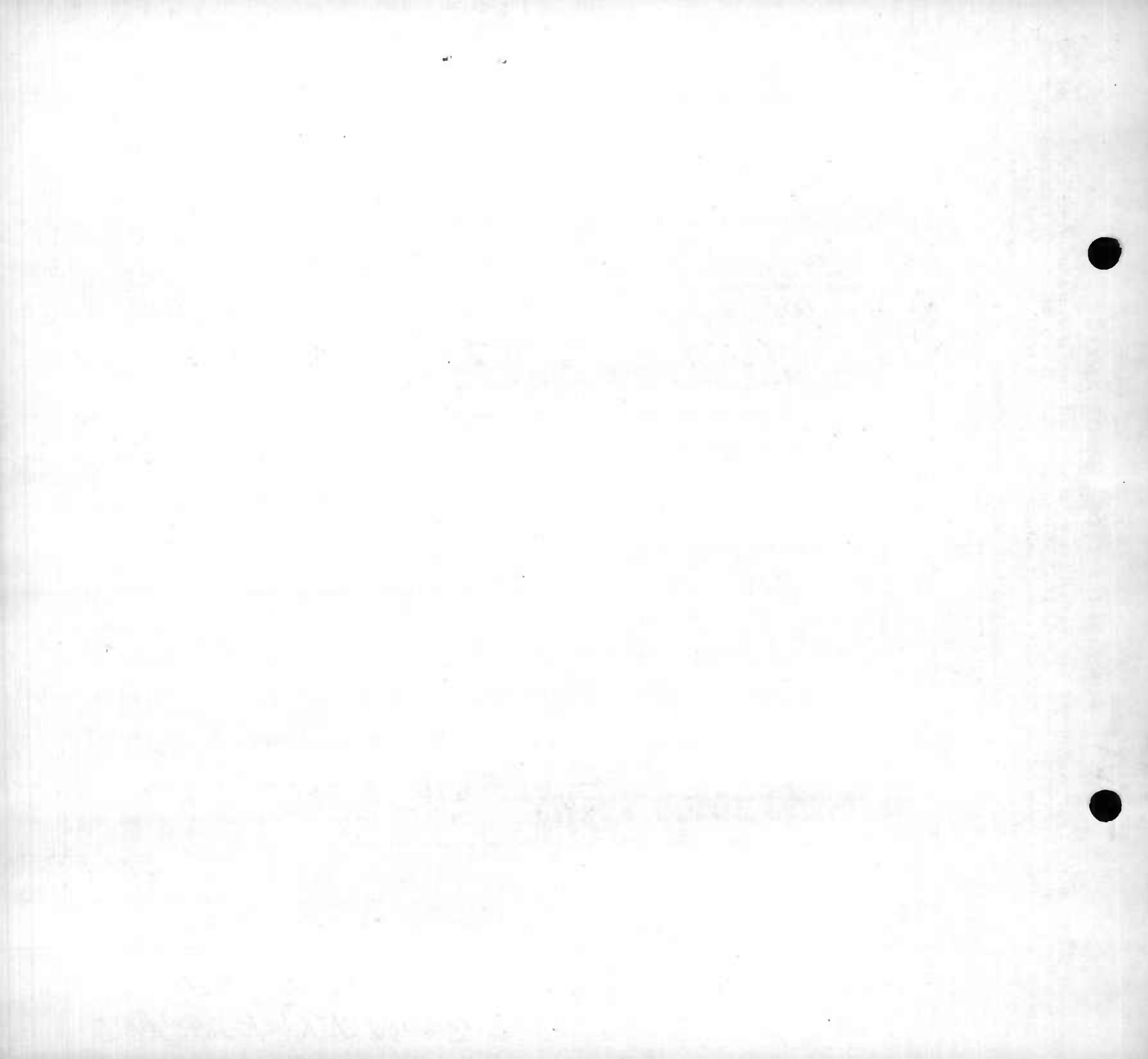
BIRTH NO. 65 2719		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2719	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Olga C. Ludwig		March 11, 1965		3:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		RURAL		63-00	
		D. STREET ADDRESS (If rural, give location)			
		3450 Yorkway 21222			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	White	Married	Aug. 19, 1918	46	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Dept Manager		A.J. Korvett		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Albert E. Clasing		Gertrude N. Neal		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		216-01-2607		RECORDS: BCH: 4940 Eastern Avenue #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		3 Hours	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II		Hypertension			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from March 11, 1965 to March 11, 1965, that (I) (we) last saw the deceased alive on March 11, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D.	Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input checked="" type="checkbox"/>
23B. DATE SIGNED		March 11, 1965			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. C. Robert Cooke		4940 Eastern Avenue Baltimore, Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	3/15/65	Gardens of Faith Cem.		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
MAR 15 1965	Robert E. Taylor, M.D.	Leonard J. Ruck Inc 5305 Harford Rd.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2720		CERTIFICATE OF DEATH		Registered No. 65 2720	
1. NAME OF DECEASED (Type or Print) <i>Ellis, Marie</i>				2. DATE AND HOUR OF DEATH <i>3/10/65 11:25 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>27-38</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>6208 Falkirk Rd -</i>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>47 North Charles General Hospital</i>									
5. SEX <i>Female</i>	6. RACE <i>W. American</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>6-13-95</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Wittich</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth Loose</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			
16. SOCIAL SECURITY NO. <i>Chart -</i>			17. INFORMANT <i>Chart -</i>						
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>420.1 I</i>				CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO (B) <i>Arterio-sclerotic Cardio-vascular Disease</i> DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <i>Sudden 3/10/65</i>  <i>?</i>	
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>3/6</i> 19 <i>65</i> to <i>3/10</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>3/10</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Joseph S. Blum M.D.</i>				23B. DATE SIGNED <i>3/10/65</i>		23C. PHYSICIAN'S NAME (Type) <i>JOSEPH S. BLUM M.D.</i>			
23D. ADDRESS <i>1115 K Calver St.</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>3-13-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1965</i>		25B. NAME OF REGISTRAR <i>Leonard V. Ruck, Inc.</i>		25C. FUNERAL DIRECTOR <i>Leonard V. Ruck, Inc.</i>		25D. ADDRESS <i>BALTO, Md.</i>			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>65 2721</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 2721</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Julia M. Colbert</b>		2. DATE AND HOUR OF DEATH <b>Mar. 10 1965 3:40 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1202</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #18</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>		D. STREET ADDRESS (If rural, give location) <b>398 E. 31st St.</b>			
5. SEX <b>Female</b>	6. RACE <b>Cauc</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widow</b>	B. DATE OF BIRTH <b>2-17-1883</b>	9. AGE (In years lost birthday) <b>82</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>Patrick Coffey</b>		14. MOTHER'S MAIDEN NAME <b>Madelyn</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Wm. P. Colbert</b>	
18. <b>4-20-11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Posterior Wall Myocardial infarction</b>		CAUSE OF DEATH (A) DUE TO <b>Arteriosclerotic Cardiovascular disease</b> (B) <b>Congestive Heart Failure</b> (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Mar 10 1965</b> to <b>Mar 10 1965</b> , that (I) (we) last saw the deceased alive on <b>Mar 10 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles F. Fletcher</b> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Mar 10, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Charles F. Fletcher</b> M.D.		23D. ADDRESS <b>Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/13/65</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Salyer</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>	
				ADDRESS <b>Balto. Md. 21214</b>	

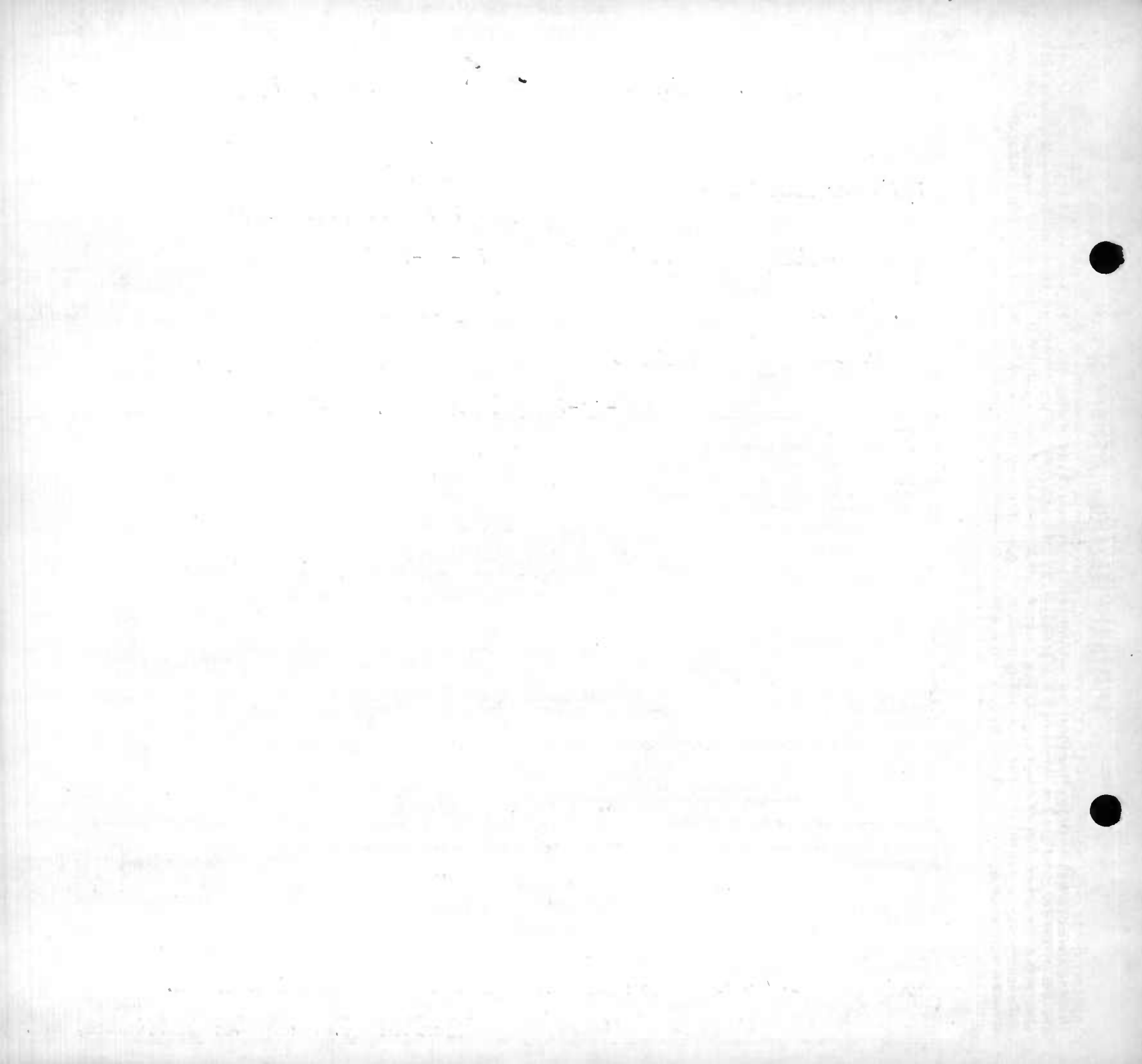


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2722				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2722	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Max B. Steinberg</u>				2. DATE AND HOUR OF DEATH <u>March 9, 1965</u> <u>2:40 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>3101 Northern Parkway</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>27-05</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>3101 Northern Parkway</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>12-29-1882</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Baker</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Albert Steinberg</u>			14. MOTHER'S MAIDEN NAME				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>220-07-1074</u>		17. INFORMANT <u>Theresa P. Steinberg</u>		ADDRESS <u>same</u>
18. <u>422.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Senility</u>			CAUSE OF DEATH (A) <u>Acute pulmonary edema</u> DUE TO (B) <u>Chronic myocarditis</u> DUE TO (C) <u>Arteriosclerotic C-V disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u> <u>12 yrs</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the <del>physician</del> ) attended the deceased from <u>Aug 20, 1953</u> to <u>March 9, 1965</u> . that (I) (we) last saw the deceased alive on <u>March 8, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>H. V. Harbold</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>March 9, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>H. V. HARBOLD</u>				23D. ADDRESS <u>4706 Xanford Road - Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>3/12/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Galt, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc</u>		ADDRESS <u>Baltimore, Md.</u>	





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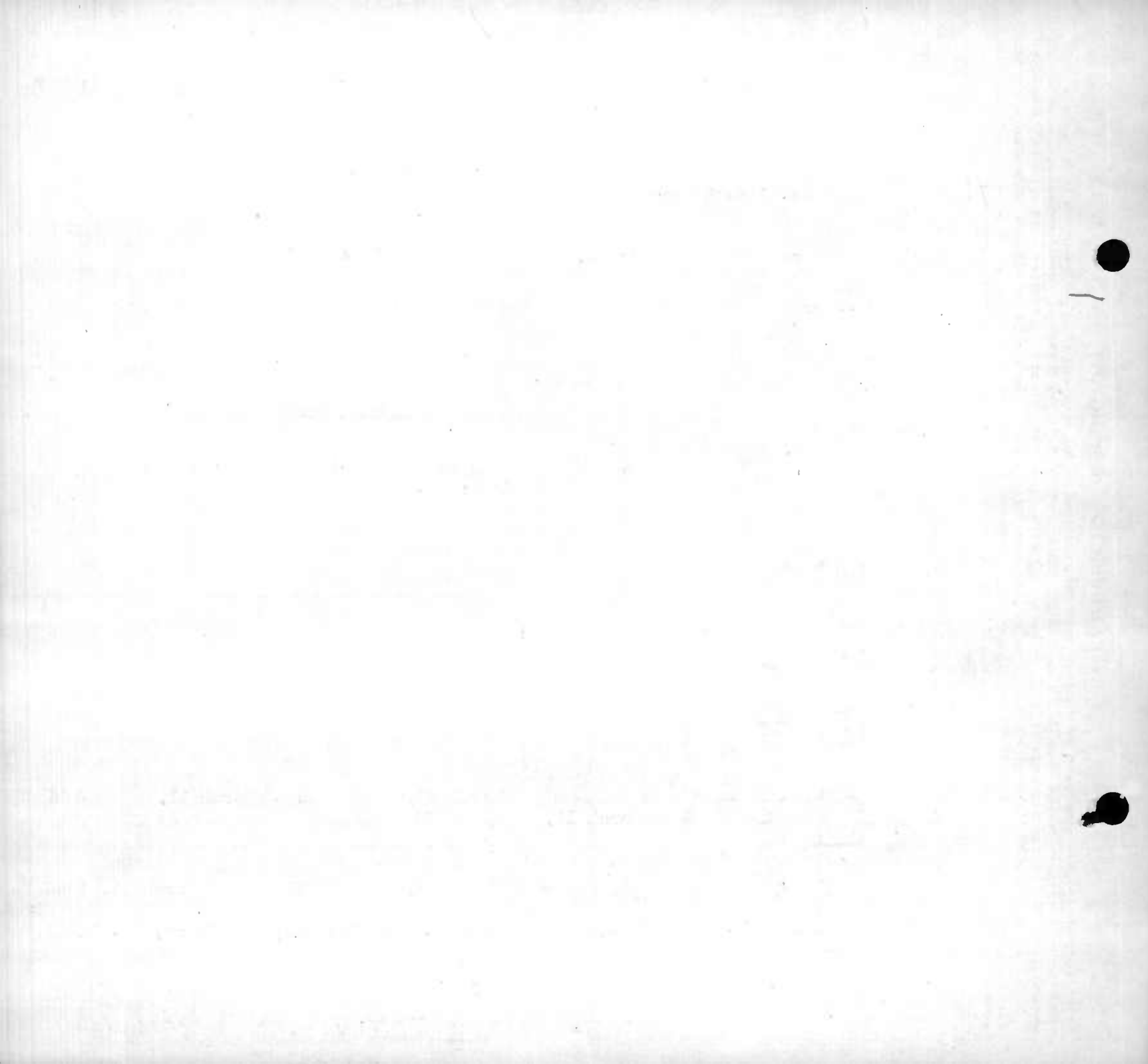
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2723</u>	
BIRTH NO. <u>65 2723</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Florence K. Dettmore</u>		2. DATE AND HOUR OF DEATH <u>March 14, 1965</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>28-41</u>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <u>4313 Chatham Road</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>4313 Chatham Road</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>April 13, 1899</u>	9. AGE (In years last birthday) <u>65 Yrs.</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Plains, Pennsylvania</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Kirwin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Duddy</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-26-9024</u>		17. INFORMANT <u>4313 CHATHAM RD.</u> <u>JAMES E. DETTMORE</u>	
18. <u>153.81</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Malignancy Colon, metastatic</u> DUE TO  (B) _____ DUE TO  (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 1965</u> to <u>March 14, 1965</u> , that (I) (we) last saw the deceased alive on <u>March 14, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Nathan E. Neefole</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>March 14, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>NATHAN E. NEEFOLE</u>		M.D.		23D. ADDRESS <u>4215 - Park Hy &amp; Dr Balto. 15 Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>3/17/65</u>	24C. NAME of CEMETERY or CREMATORY <u>St. Mary's Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Hanover Township, Pennsylvania</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Stachurski</u>		25C. FUNERAL DIRECTOR <u>Ellsworth Armacost</u> ADDRESS <u>4600 Liberty Hgts. Ave</u>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2724		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2724	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Scott, Fayette</b>			March 11, 1965 1:50 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Joseph Hospital</b>			A. STATE <b>Maryland</b> B. COUNTY <b>8-06</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21213</b>		
			D. STREET ADDRESS (If rural, give location) <b>1719 N. Washington St.</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married.</b>	8. DATE OF BIRTH <b>March 15, 1914</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Edward Livingston</b>			14. MOTHER'S MAIDEN NAME <b>MAMIE Hayges</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT ADDRESS <b>Celia L. Cousins 941 N. Rosedale St.</b>		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Old and fresh anterior myocardial infarcts.</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <b>Old and fresh anterior myocardial infarcts.</b> (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 10, 1965</b> to <b>March 11, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 11, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William B. VandeGrift</b>			23B. DATE SIGNED <b>March 12, 1965</b>		23C. PHYSICIAN'S NAME (Type) <b>William B. VandeGrift</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>3-15-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial (B &amp; H Co) Arbutus Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>1735 Hanford Ave.</b>



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2725		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2725	
M.E. CASE NO.			1. NAME OF DECEASED		
(Type or Print) RIDDELL, George C.			2. DATE AND HOUR OF DEATH 3/11/65 10:50 p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hosp.			A. STATE Md B. COUNTY 26-11		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto 24			D. STREET ADDRESS (If rural, give location) 3202 Fleet St		
5. SEX M.	6. RACE W.	7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6-18-07	9. AGE (In years last birthday) 57	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beth Steel Engineer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Elisabeth Riddell		
14. MOTHER'S MAIDEN NAME Margaret Hotwood			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 315070169			17. INFORMANT'S ADDRESS Mildred Riddell - Above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST.			(A) Myocardial Infarction 2 days		
			(B) Coronary Insufficiency		
			(C) ASD		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-9-65 19 to 3-11-65 19, that (I) (we) last saw the deceased alive on 3-11-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Antoine Arrage M.D.				23B. DATE SIGNED 3/11/65	
23C. PHYSICIAN'S NAME (Type) ANTOINE ARRAGE M.D.				23D. ADDRESS Church Home & Hosp.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 3-15-65		24C. NAME OF CEMETERY OR CREMATORY Meadowlark Cem	
24D. LOCATION (City, town, or county) Dorsey		24E. STATE Ind			
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Connor	
				ADDRESS John J. Connor, Balto, Ind.	

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Margaret + Herbert

Boat 2nd  
George W. White

Place and  
date of birth  
and

2-11-21

George W. White

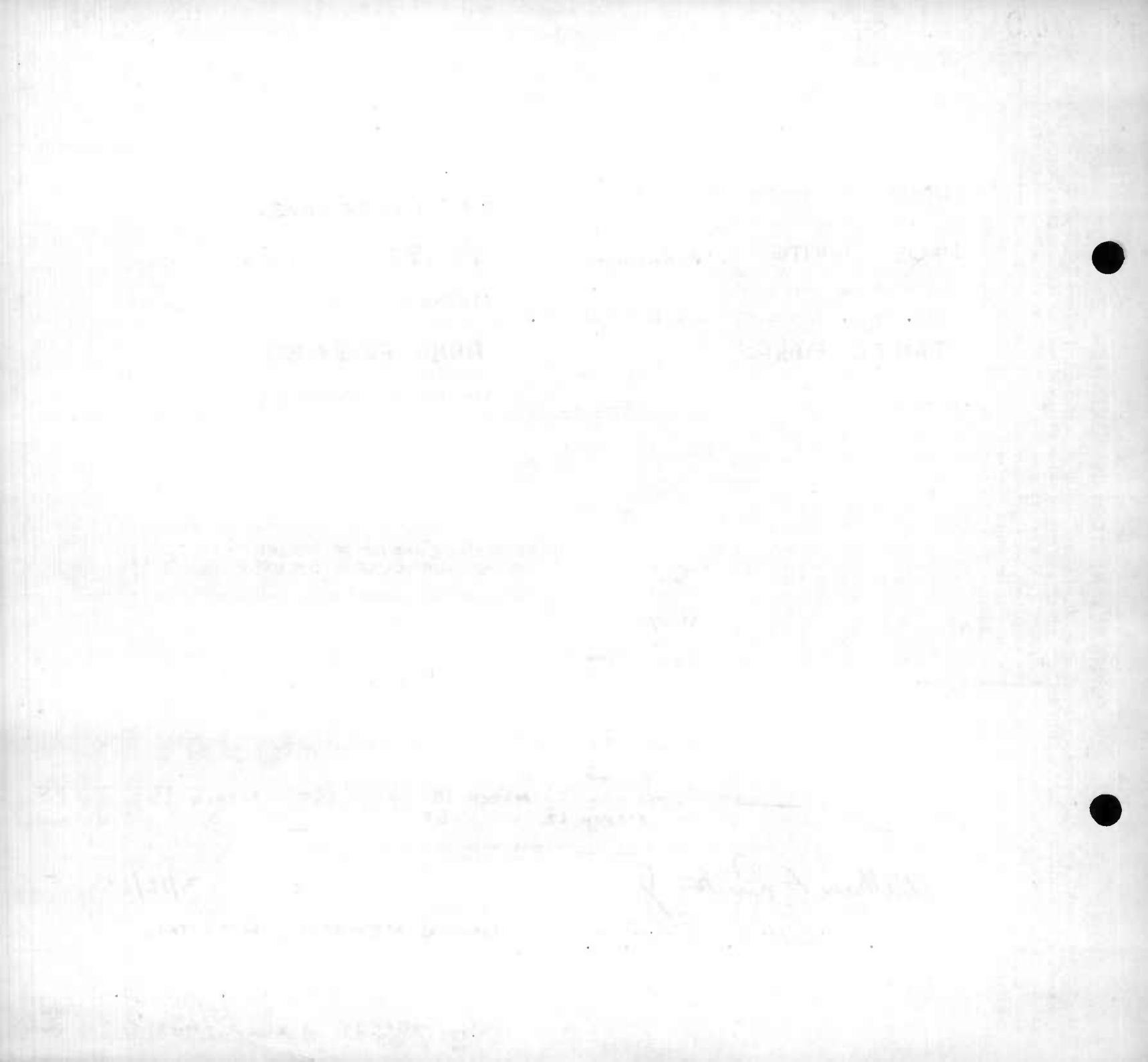
ARRIVING AIRMAIL



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				65 2726	
BIRTH NO. 65 2726				Registered No. 65 2726	
M.E. CASE NO.				60-01	
1. NAME OF DECEASED (Type or Print) <b>JOHN E. BAHR</b>			2. DATE AND HOUR OF DEATH <b>MARCH 12, 1965 11:58 A. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2707</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2918 LOUISE AVE.</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9/29/90</b>	9. AGE (In years lost birthday) <b>74</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Supt. of Shops</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Standard Oil Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>DANIEL BAHR</b>		
14. MOTHER'S MAIDEN NAME <b>ANNA FELDMAN</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <b>UNKNOWN No</b>		
16. SOCIAL SECURITY NO. <b>214-01-4088</b>			17. INFORMANT ADDRESS <b>HOSPITAL RECORDS</b>		
18. <b>332 X 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL THROMBOSIS, LEFT</b>			INTERVAL BETWEEN ONSET AND DEATH <b>48 HOURS</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HYPERTENSIVE AND ARTERIOSCLEROTIC</b>			DUE TO <b>CEREBROVASCULAR DISEASE</b> <b>5 YEARS</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 10 1965</b> to <b>MARCH 12 1965</b> , that (I) (we) last saw the deceased alive on <b>MARCH 12 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William R. Linton, Jr.</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>3/12/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. WILLIAM R. LINTON, JR.</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-15-1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Moreland Memorial Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Joseph J. Funeral Home 7401 Belair Road (36)</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-01080				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2727	
M.E. CASE NO. 65 2727				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
NORMILE BABY GIRL				MARCH 11 1965		7:30P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE MD B. COUNTY			
ST AGNES HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE 21228 53-00			
				D. STREET ADDRESS (If rural, give location)			
				429 GREENLOW RD.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
FEMALE	WHITE		MARCH 11, 1965		3 2		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				BALTIMORE			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
RICHARD H. NORMILE				KATHRYN LANG			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
				ST AGNES HOSPITAL CATON & WILKENS AVE.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) Premature partial separation of placenta at 8 weeks gestation			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MARCH 11 1965 to MARCH 11 1965, that (I) (we) last saw the deceased alive on MARCH 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
24A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
D. Robert Giannandi						March 12, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				St Agnes Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town or county) (State)	
BURIAL		3/17/65		ST. PATRICKS		BINGHAMTON, N.Y.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 15 1965		Robert S. Giannandi		257 S. MAC NABD		301 FREDERICK 21228	

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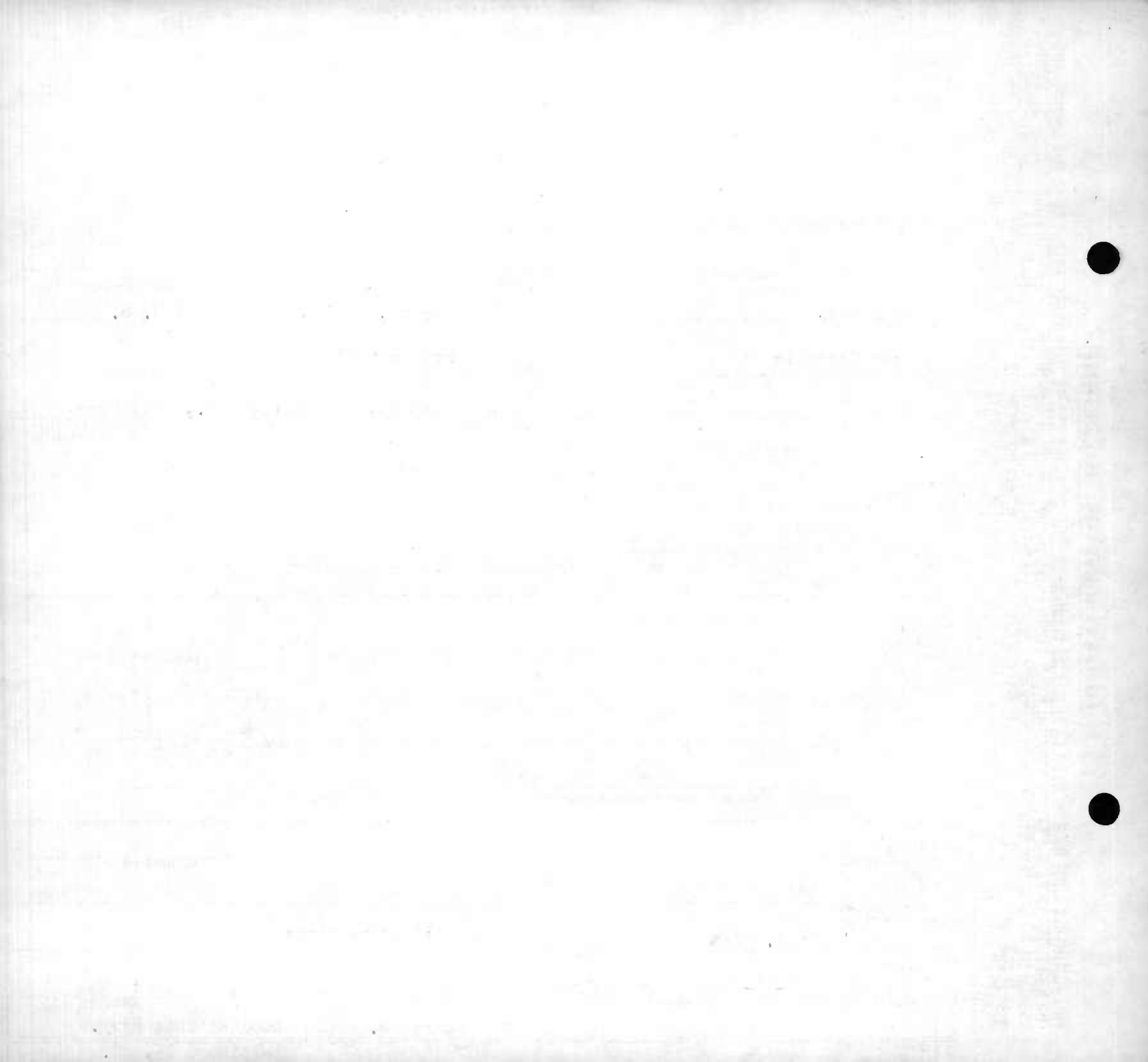
NEW YORK

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2728		BALTIMORE CITY HEALTH DEPT. <b>CERTIFICATE OF DEATH</b>		Registered No. 65 2728	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Hannah M. Twomey</i>			2. DATE AND HOUR OF DEATH <i>3-9-65</i>   <i>2<sup>00</sup> A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Lake Drive Nursing Home</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>23</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1717 Clarkson St.</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>4-4-91</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Limerick, Ireland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		13. FATHER'S NAME <i>John Costello</i>		14. MOTHER'S MAIDEN NAME <i>Mary McGrail</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>John Twomey, 4211 Doris Ave., Baltimore 25</i>	
18. <i>334X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <i>Cerebrovascular Art- sclerosis</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>sev. years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2/15</i> 19 <i>63</i> to <i>3/9</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>3/8</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Louis V. Blum M.D.</i>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3/9/65</i>
23C. PHYSICIAN'S NAME (Type) <i>Louis V. Blum</i>			23D. ADDRESS <i>2310 Eutaw Place</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-12-1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Stodley M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>George J. Gonce 4001 Ritchie Hwy. Baltimore 25, Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2729		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2729	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) TENLEY, SR., ERNEST B.		2. DATE AND HOUR OF DEATH 3-10-65 5:14 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ZONE #29 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 20-08 D. STREET ADDRESS (If rural, give location) 116 S. COLLINS AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-7-90	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A. 2730
13. FATHER'S NAME WESLEY TENLEY			14. MOTHER'S MAIDEN NAME BARBARA LINDNER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215 09 2277		17. INFORMANT ADDRESS ST. AGNES RECORDS, WILKENS & CATON	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH (A) LUL PNEUMONIA (POST-OP.) DUE TO (B) INOPERABLE CA, RECTUM DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 19 19 65 to MARCH 10 19 65, that (I) (we) last saw the deceased alive on MARCH 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wenifredo N. Iglesia M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 3-10-65	
23C. PHYSICIAN'S NAME (Type) WENIFREDO N. IGLESIA M.D.				23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-13-1965		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEM	
24D. LOCATION BALTO		24E. LOCATION (City, town, or county) (State) MD		24F. LOCATION (City, town, or county) (State) MD	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1965		25B. NAME OF REGISTRAR Robert E. Starnes		25C. FUNERAL DIRECTOR WEEBER FUNERAL HOME 5391 EDMONDSON AVE. #29	



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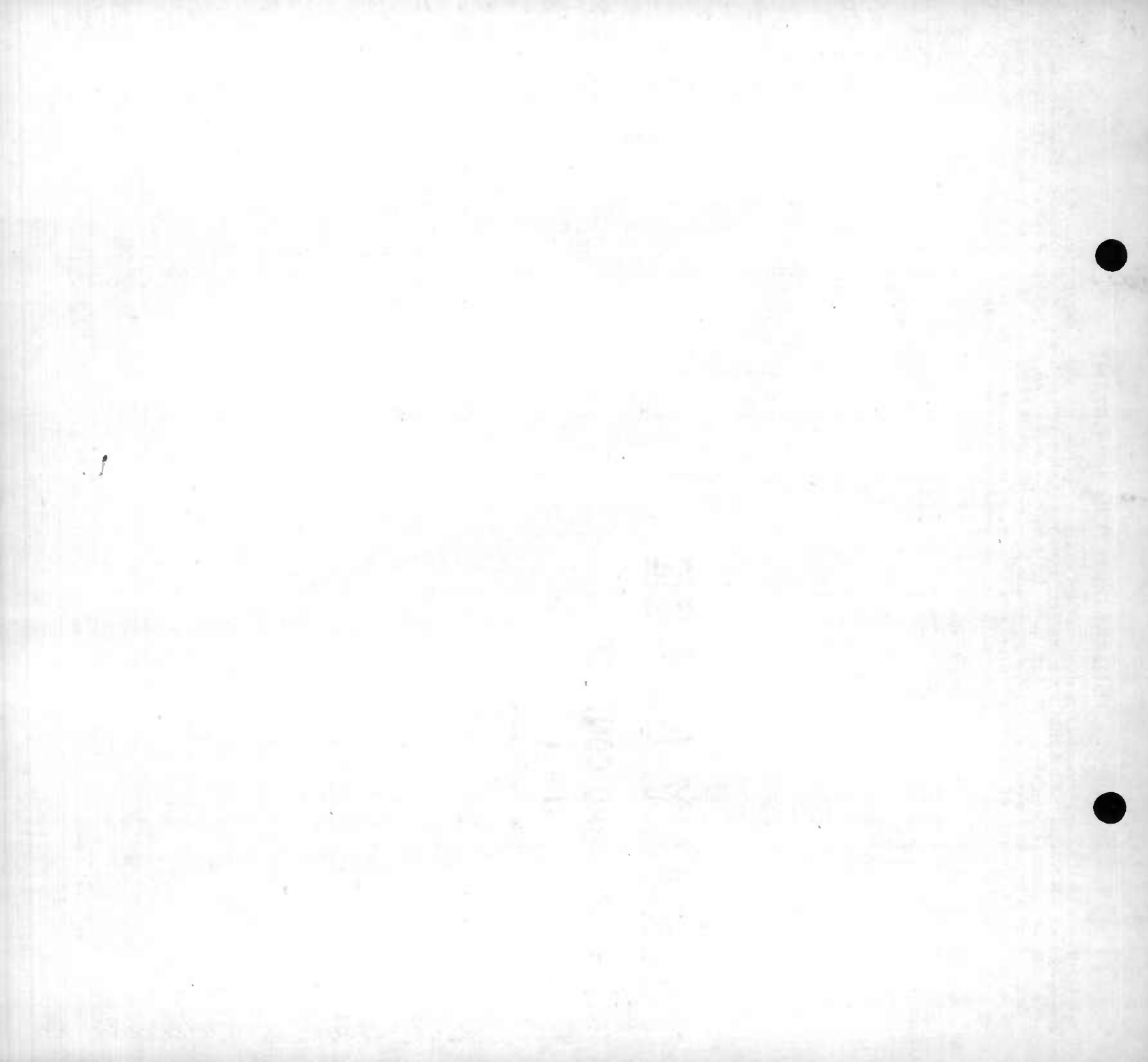
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# FUNERAL DIRECTOR: IMPORTANT

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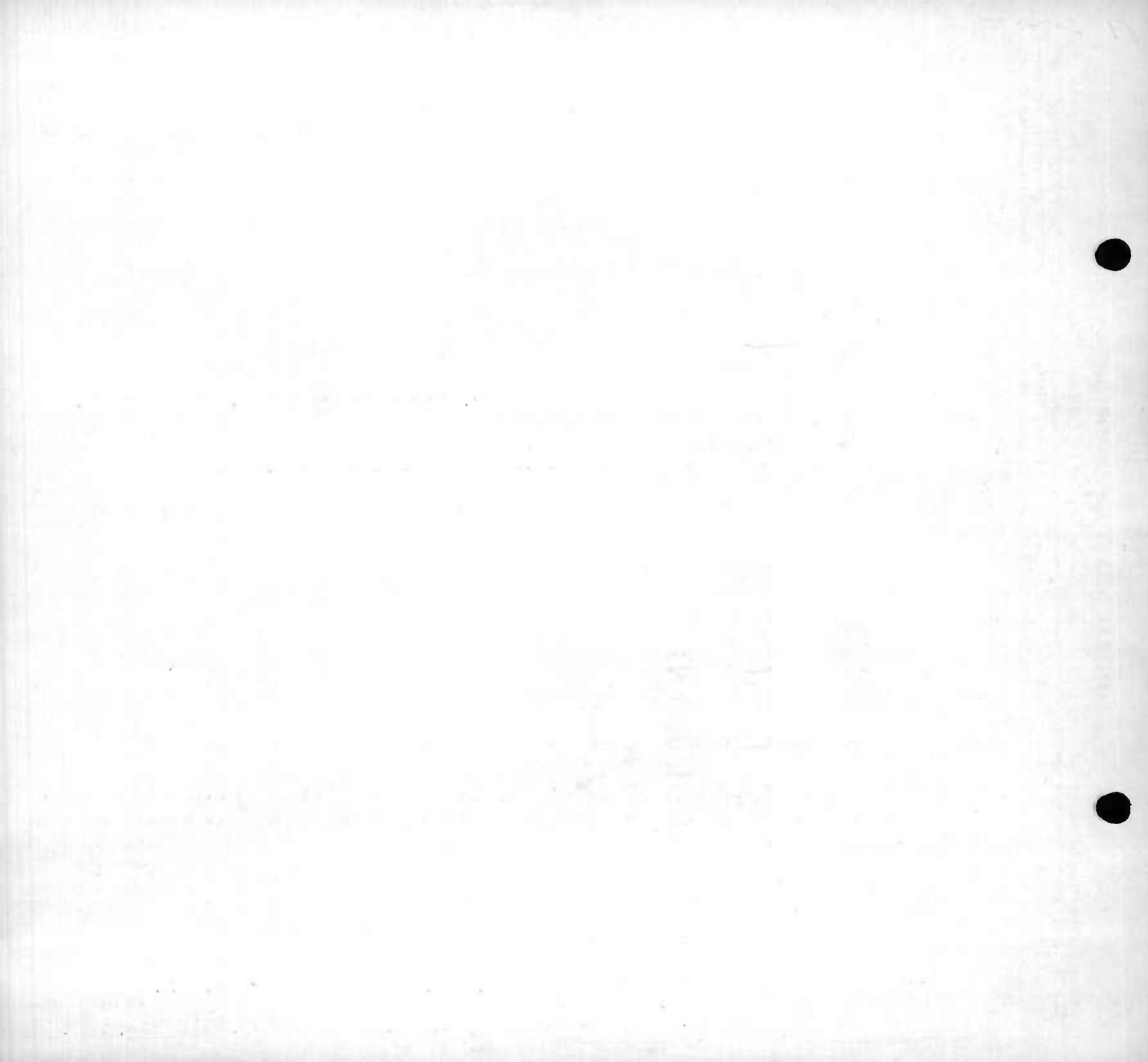
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2730	
BIRTH NO. 65 2730		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>IDA R. BOWLING</i>		2. DATE AND HOUR OF DEATH <i>3/8/65</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>26-10</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2701 BAVERNWOOD AVE</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO</i>			
		D. STREET ADDRESS (If rural, give location) <i>407 N. CLINTON</i>			
5. SEX <i>F</i>	6. RACE <i>W.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOW</i>	8. DATE OF BIRTH <i>JULY 8, 1887</i>	9. AGE (In years lost birthday) <i>77</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>COOK</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>?</i>		11. BIRTHPLACE (State or foreign country) <i>BALTO</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>FREDERICK PRILLER</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>		16. SOCIAL SECURITY NO. <i>212-267-151A</i>		17. INFORMANT <i>DAUGHTER</i>	
18. <i>420111</i>		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial Infarction sudden</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 + yr.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <i>Myocardial degeneration 1 + yr.</i>		(B) DUE TO <i>Arteriosclerotic Cardiovascular 10 yr.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Cerebro Vascular - ischemia</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>✓</i>		20A. AUTOPSY? (Yes or No) <i>✓</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>✓</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>✓</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <i>✓</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>✓</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>Mar 1</i> 19 <i>65</i> to <i>Mar 8</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Mar 8</i> 19 <i>65</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Frank</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3/10/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>F.T. KASIK JR</i>		23D. ADDRESS <i>9005 HARFORD RD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>3/11/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>HOLY REDEEMER</i>	
24D. LOCATION <i>BALTO MD</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Gable</i>		25C. FUNERAL DIRECTOR <i>P.A. HENNING</i>	
				ADDRESS <i>6067 HARFORD RD.</i>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2731				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2731	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Hagen, Hannah May</b>				2. DATE AND HOUR OF DEATH <b>3-11-65 1 7<sup>40</sup> A.M.</b>			
3. PLACE OF DEATH <b>IN BALTIMORE, MARYLAND</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>md.</b> B. COUNTY <b>Baltimore</b> <b>2302</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>6 E. Hamburg</b>							
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>5-24-21</b>	9. AGE (In years lost birthday) <b>43</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bar maid</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Henry Price</b>				14. MOTHER'S MAIDEN NAME <b>Rinda Bell</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Harry Hagen</b>		ADDRESS <b>6 E. Hamburg St.</b>	
18. <b>330X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Intestinal hemorrhage</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Ruptured aneurysm - cerebral</b>				CAUSE OF DEATH (A) <b>Intestinal hemorrhage</b> DUE TO (B) <b>Ruptured aneurysm - cerebral</b> DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>3-5-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>cerebral aneurysm</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>March 1</b> 19 <b>65</b> to <b>March 11</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>March 11</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Richard P. Norgaard</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>11 March 65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Richard P. Norgaard</b> M.D.		23D. ADDRESS <b>University Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/15/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Baker, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>JOHN F. DENNY, INC. 715 Light St</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 2732	
BIRTH NO. 65 2732		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WEISMAN IRENE EMMA.		2. DATE AND HOUR OF DEATH 3/11/65 112-58 AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital Baltimore				A. STATE Maryland B. COUNTY Baltimore			
5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed				8. DATE OF BIRTH 5/25/84		9. AGE (In years last birthday) 80 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? America				13. FATHER'S NAME Frank Berger			
14. MOTHER'S MAIDEN NAME Emma Kruse				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. none				17. INFORMANT Harry Lee Weisman Jr. 2816 Louise Ave. #14			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				19. CAUSE OF DEATH Rupture Aneurysm - abdominal Aorta Generalized atherosclerosis			
19. INTERVAL BETWEEN ONSET AND DEATH				20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				22. MEDICAL CERTIFICATION			
19A. DATE OF OPERATION 3/31/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Aneurysm		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 3/11/65 to 3/11/65, that (I) (we) last saw the deceased alive on 3/11/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE K. M. Anand	
23B. DATE SIGNED 3/11/65		23C. PHYSICIAN'S NAME (Type) K. M. ANAND		23D. ADDRESS Union Memorial Hospital		23E. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3317 Brehms Lane #13	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 3/13/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1965		25B. NAME OF REGISTRAR Robert E. Talley		25C. ADDRESS		25D. ADDRESS	

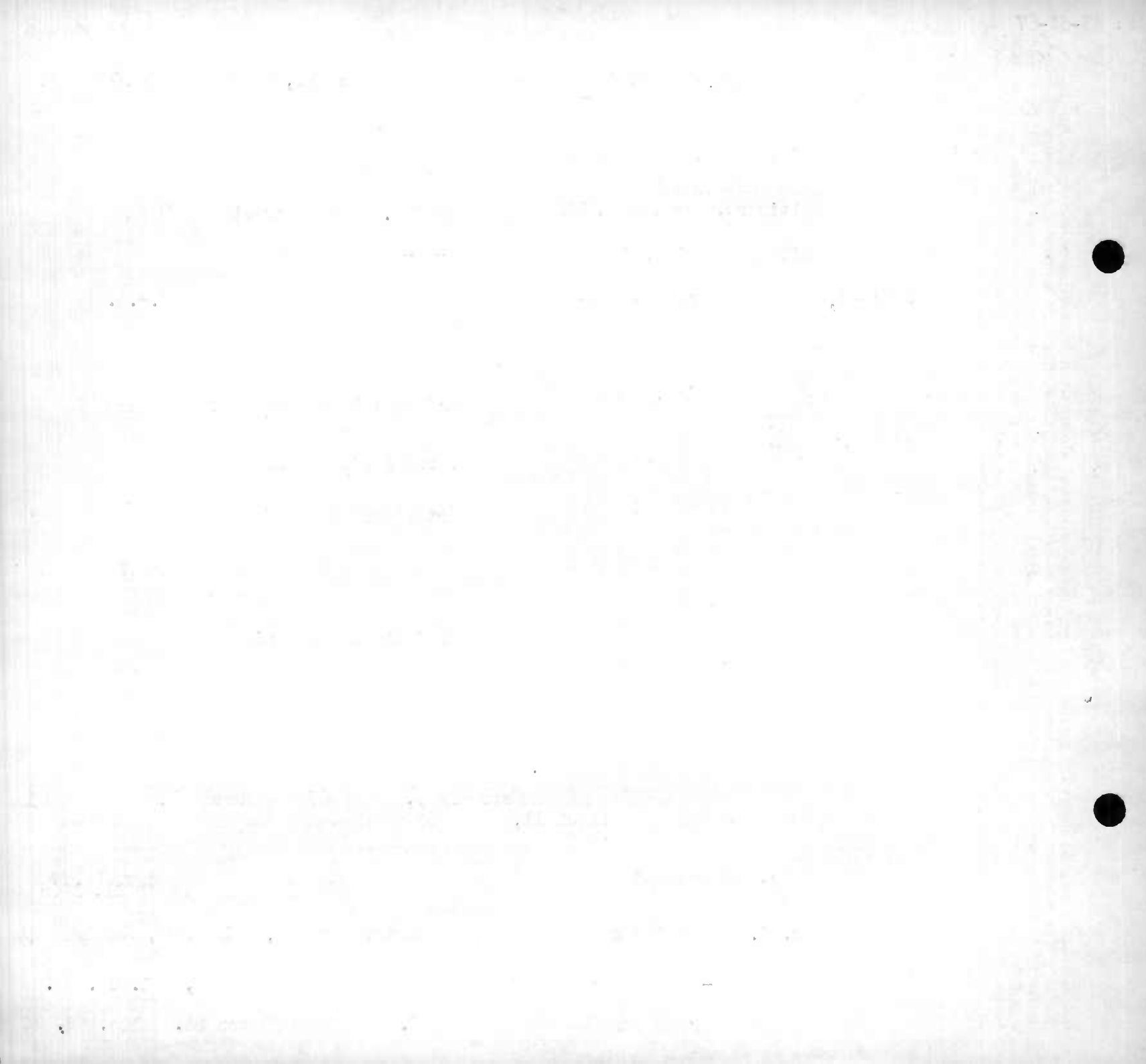
TIAN, M., J.



IS: 43-51-67  
Z 2  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 65 2733		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2733	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Michael Zyski		March 11, 1965		10:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 26-36	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		1108 S. Bonsal Street		21224	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9-22-79	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired,		10B. KIND OF BUSINESS OR INDUSTRY Lithographer		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Not Known	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #24	
18. 350X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Parkinson's Disease (B) DUE TO Arteriosclerosis (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Aspiration Pneumonia			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 3, 1965 to March 11, 1965, that (I) (we) last saw the deceased alive on March 11, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. R. Cooke		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED March 11, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. C. Robert Cooke		23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE March 15-1965		24C. NAME of CEMETERY or CREMATORY Sacred Heart of Mary	
24D. LOCATION German Hill Road, Bal. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR JOHN J. DUDA	
25D. ADDRESS 2829 Hudson St. Balto. Md. 24					



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2734

1. NAME OF DECEASED  
(Type or Print)

WALTER P. MORRISON

2. DATE AND HOUR PRONOUNCED DEAD

March 12, 1965 6:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Middle River (20)

D. STREET ADDRESS (If rural, give location)

1203 Cord Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 29, 1907

9. AGE (In years  
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Maintenance Man

10B. KIND OF BUSINESS OR INDUSTRY

Steel Mill

11. BIRTHPLACE (State or foreign country)

Tenn.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Milburn Morrison

14. MOTHER'S MAIDEN NAME

Alice ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

410-09-6556

17. INFORMANT

Bonnie Morrison Same

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoporosis, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/13/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/15/65

23C. NAME of CEMETERY or CREMATORY

Meadowridge Memorial Park

23D. LOCATION (City, town, or county)

Howard Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

24B. NAME OF REGISTRAR

Robert E. Talbot, M.D.

24C. FUNERAL DIRECTOR

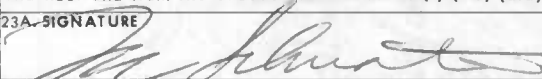
Bruzdzinski Funeral Home 1407 Eastern Ave.

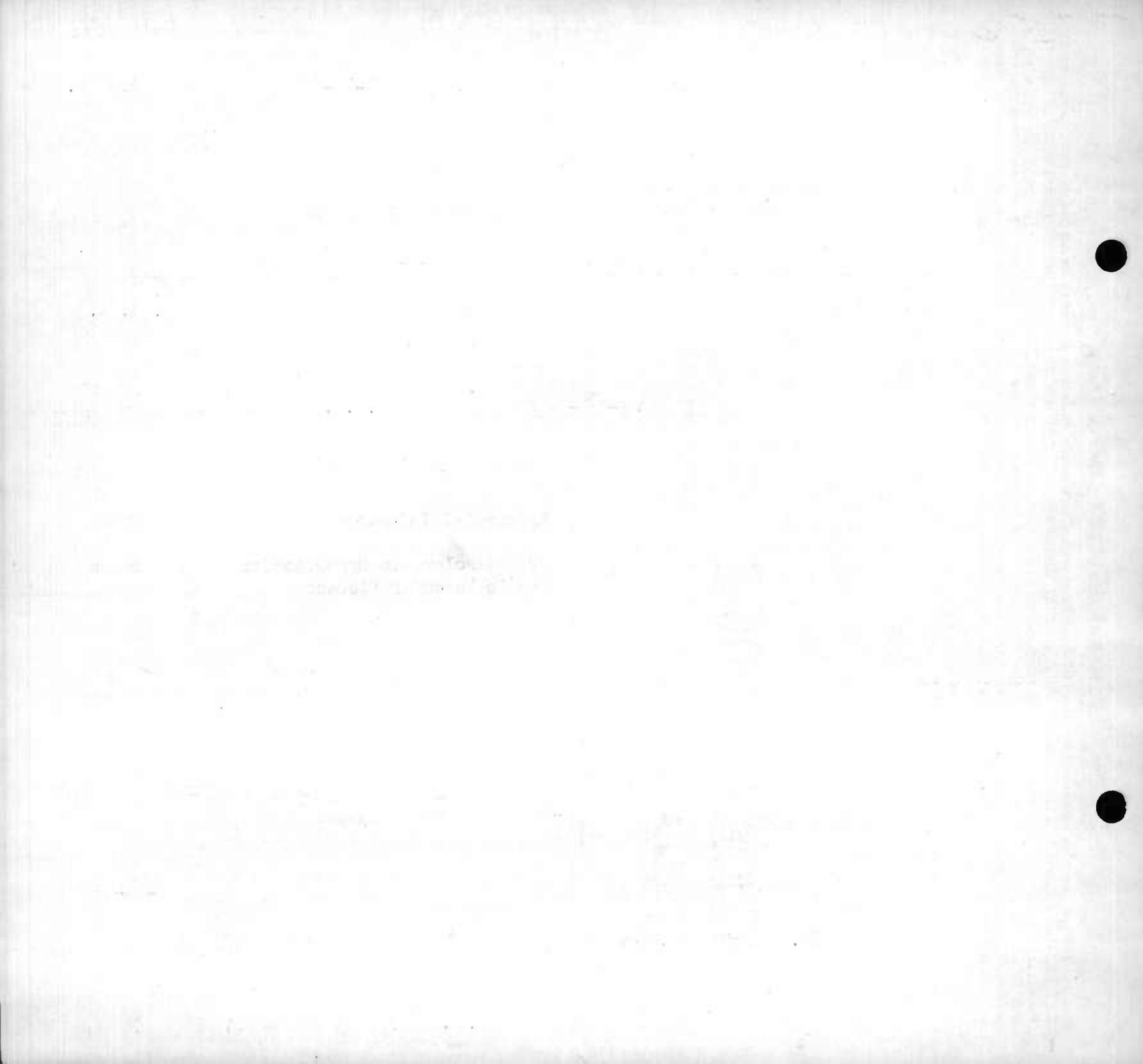
ADDRESS

Class 1/2

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2735				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2735	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Bertha Celmer (Bertha B.)</b>				2. DATE AND HOUR OF DEATH <b>3-12-65 6:30 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-09</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3601 Fait Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	B. DATE OF BIRTH <b>10-6-06</b>	9. AGE (In years lost birthday) <b>58</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Joseph Bodniak</b>				
14. MOTHER'S MAIDEN NAME <b>Victoria (Dora) Guzinska</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <b>219-22-3207</b>			17. INFORMANT <b>Mr. Jess W. Celmer, 3601 Fait Avenue</b> <b>RECORDS: B.C.H. 4940 Eastern Avenue #21224</b>				
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Ventricular Fibrillation</b> DUE TO (B) <b>Myocardial Infarct</b> DUE TO (C) <b>Arteriosclerotic Hypertensive Cardio Vascular Disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-12-65</b> to <b>3-12-65</b> , that (I) (we) last saw the deceased alive on <b>3-12-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>3-12-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. Marvin Schuster</b>				23D. ADDRESS <b>4940 Eastern Avenue #21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/16/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary</b>		24D. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>M. E. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>			

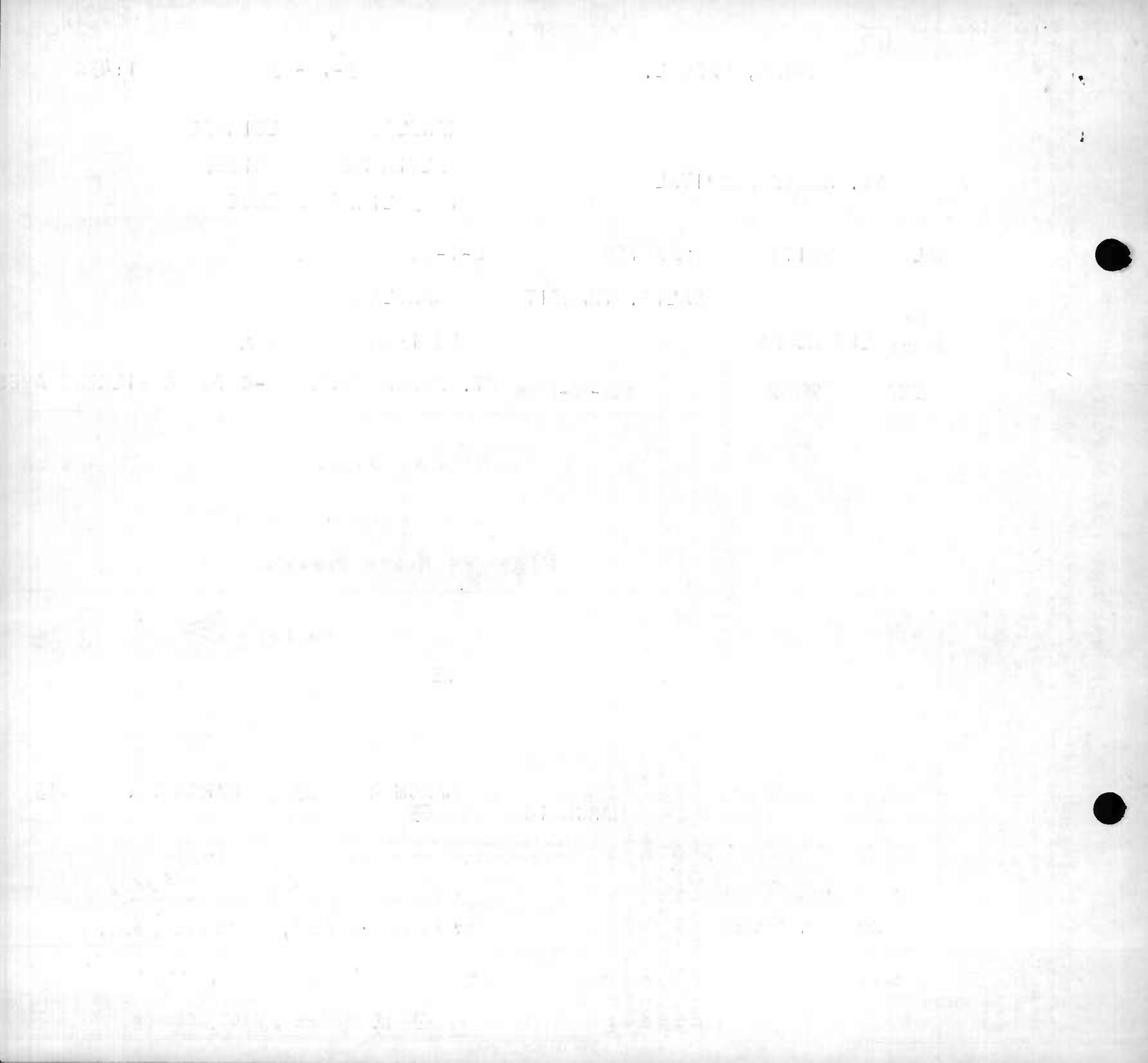


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>65 2736</u>	
BIRTH NO. <u>65 2736</u>		<b>CERTIFICATE OF DEATH</b>					
M.E. CASE NO. <u>65 2736</u>		1. NAME OF DECEASED (Type or Print) <b>MOORE, WARD L.</b>				2. DATE AND HOUR OF DEATH <b>3-10-65 1:45A</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21227</b> D. STREET ADDRESS (If rural, give location) <b>1225 LINDEN AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8-1-88</b>	9. AGE (In years lost birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>BALTO. TRANSIT</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert LEE MOORE</b>				14. MOTHER'S MAIDEN NAME <b>ZENKFER Zenophine F.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>213-05-9498</b>		17. INFORMANT ADDRESS <b>ST. AGNES RECORDS - CATON &amp; WILKENS AVES</b>			
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Renal Failure</b>		CAUSE OF DEATH (A) DUE TO <b>Nephrosclerosis +</b> (B) DUE TO <b>Chronic Pyelonephritis</b> (C) DUE TO <b>Massive Acute Myocardial Infarction</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b>	
19. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 4 19 65</b> to <b>MARCH 10 19 65</b> , that (I) (we) last saw the deceased alive on <b>MARCH 10 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Frank M. Detore</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/10/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Frank M. Detore</b>				23D. ADDRESS M.D. <b>St. Agnes Hospital, Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/13/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Howard County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>		25B. NAME OF REGISTRAR <i>Robert E. Stahly</i>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave. 21229</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2737		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2737	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Wesley Reed, Sr.</b>			2. DATE AND HOUR OF DEATH <b>March 8, 1965</b> 7 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balt</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Chase</b> D. STREET ADDRESS (If rural, give location) <b>Eastern Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>2-28-91</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Farmer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Henry Crockspon</b>			14. MOTHER'S MAIDEN NAME <b>Florence Reed</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-24-6753</b>	17. INFORMANT <b>RECORDS*BCH 4940 Eastern Aven #21224</b>		
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Aspiration Pneumonitis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Recurrent Cerebral Vascular Accidents</b>			CAUSE OF DEATH (A) <b>Aspiration Pneumonitis</b> DUE TO (B) <b>Recurrent Cerebral Vascular Accidents</b> DUE TO (C) _____		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arterio Sclerotic Cerebral Vascular Disease-Hypertensive Cardio Vascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-1 2-22 1965</b> to <b>3-8 1965</b> , that (I) (we) last saw the deceased alive on <b>3-8 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. M. Schuster</b>			23B. DATE SIGNED <b>3-8-65</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. M. Schuster</b>			23D. ADDRESS <b>BCH-4940 Eastern Avenue - #21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/13/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Sharp St. Methodist Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Chase, Balto. Co. Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Gaskins</b>	25C. FUNERAL DIRECTOR <b>James B. Gaskins F.D.</b> Address <b>Jarring Funeral Home, Aberdeen, Md.</b>		

Letter from B.C.H.

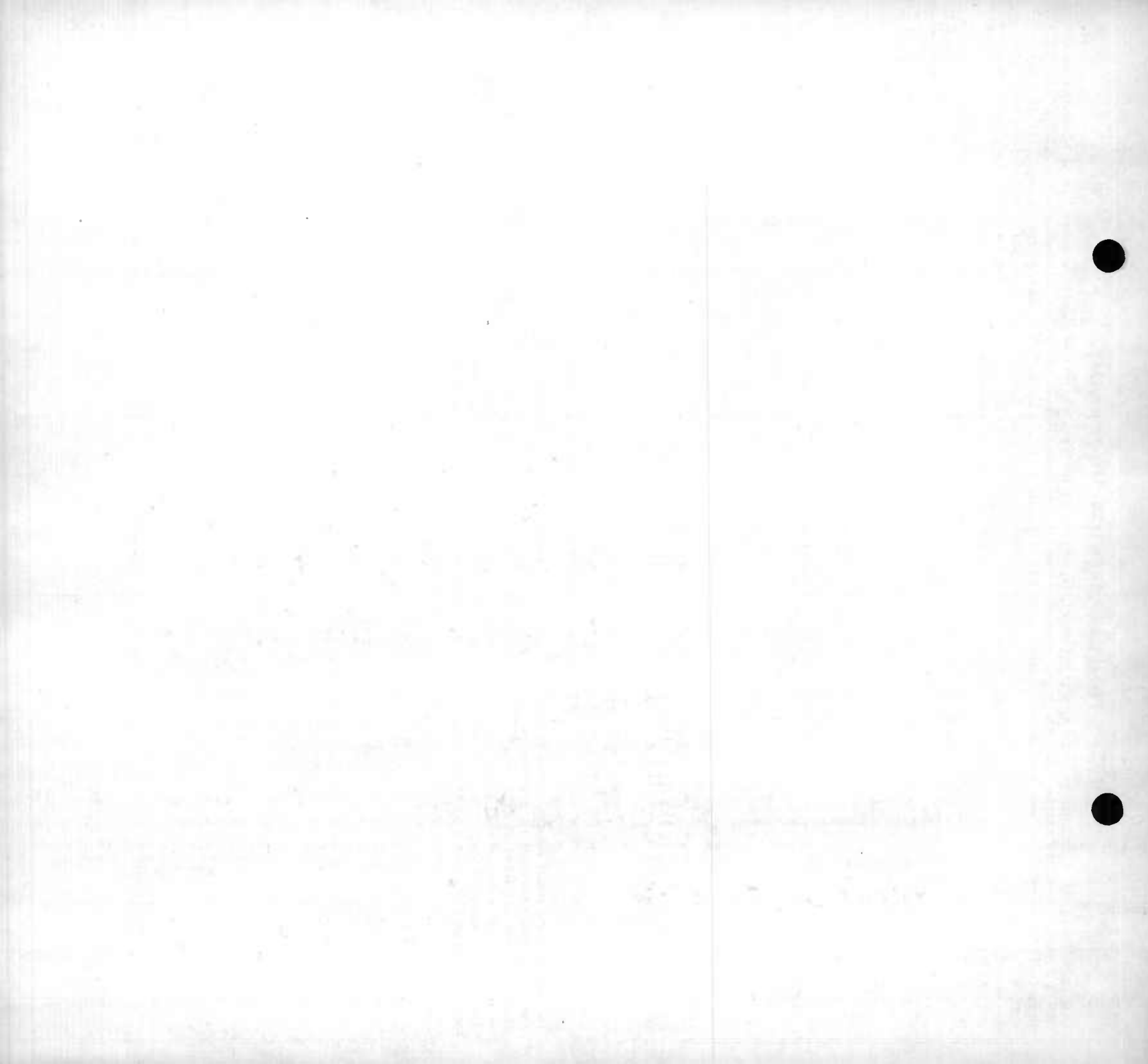
3-18-65

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2738				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2738	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MARY DEBINSKI</b>				2. DATE AND HOUR OF DEATH <b>MARCH 10, 1965 1:30 P.M.</b>			
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>203</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1910 FLEET ST.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>1910 FLEET ST</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>7-28-1884</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>BEGEIR</b>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>BEN DEBINSKI 1813 BURNWOOD RD</b>		
18. <b>422.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Insufficiency 3 days</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO <b>Chronic Myocarditis 2 yrs</b>		(B) DUE TO <b>Hypertrophy of heart 2 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>Chronic Arthritis</b>		<b>3 yrs</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 2 1964</b> to <b>March 10 1965</b> that (I) (we) last saw the deceased alive on <b>March 31 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John V. Sogorbich</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <b>1802 Eastern Ave.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-15-1965</b>		24C. NAME of CEMETERY or CREMATORY <b>HOLY ROSARY CEMETERY BUNDALK</b>		24D. LOCATION (City, town, or county) (State) <b>MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Stokely</b>		25C. FUNERAL DIRECTOR <b>JOHN M. WEBER</b>		25D. ADDRESS <b>1401 S. CHESTER ST</b>	



B-530

65 2739

BALTIMORE CITY HEALTH DEPARTMENT

65 2739

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DAVID G. BENNETT

2. DATE AND HOUR PRONOUNCED DEAD

March 13, 1965 2:35 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3403 Woodbrook Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Aug. 13, 1895

9. AGE (in years last birthday)

69

If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Gabriell A. Bennett

14. MOTHER'S MAIDEN NAME

Fammie Clayton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

579-05-6664

17. INFORMANT

ADDRESS

Mrs. Carrie Bennett 3403 Woodbrook Ave.

18. 133.8 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Large Bowel.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED  
3/14/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

3/17/65

23C. NAME of CEMETERY or CREMATORY

St Peter Cemetery

23D. LOCATION (City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

24B. NAME of REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

William C. March 928 E. North Ave.

ADDRESS

Class 1



65 2740

BALTIMORE CITY HEALTH DEPARTMENT

65 2740

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

OSCAR JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

March 10, 1965 9:58 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3012 Reisterstown Road

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

7

9. AGE (In years  
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

EDWARD JOHNSON

14. MOTHER'S MAIDEN NAME

MARGARET

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

212-12-5171

17. INFORMANT

ADDRESS

Mrs Dorothy Jones 3012 Reistertown Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, lorn, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
3/11/6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/15/65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Adolphus Halstead 918 Druid Hill Ave

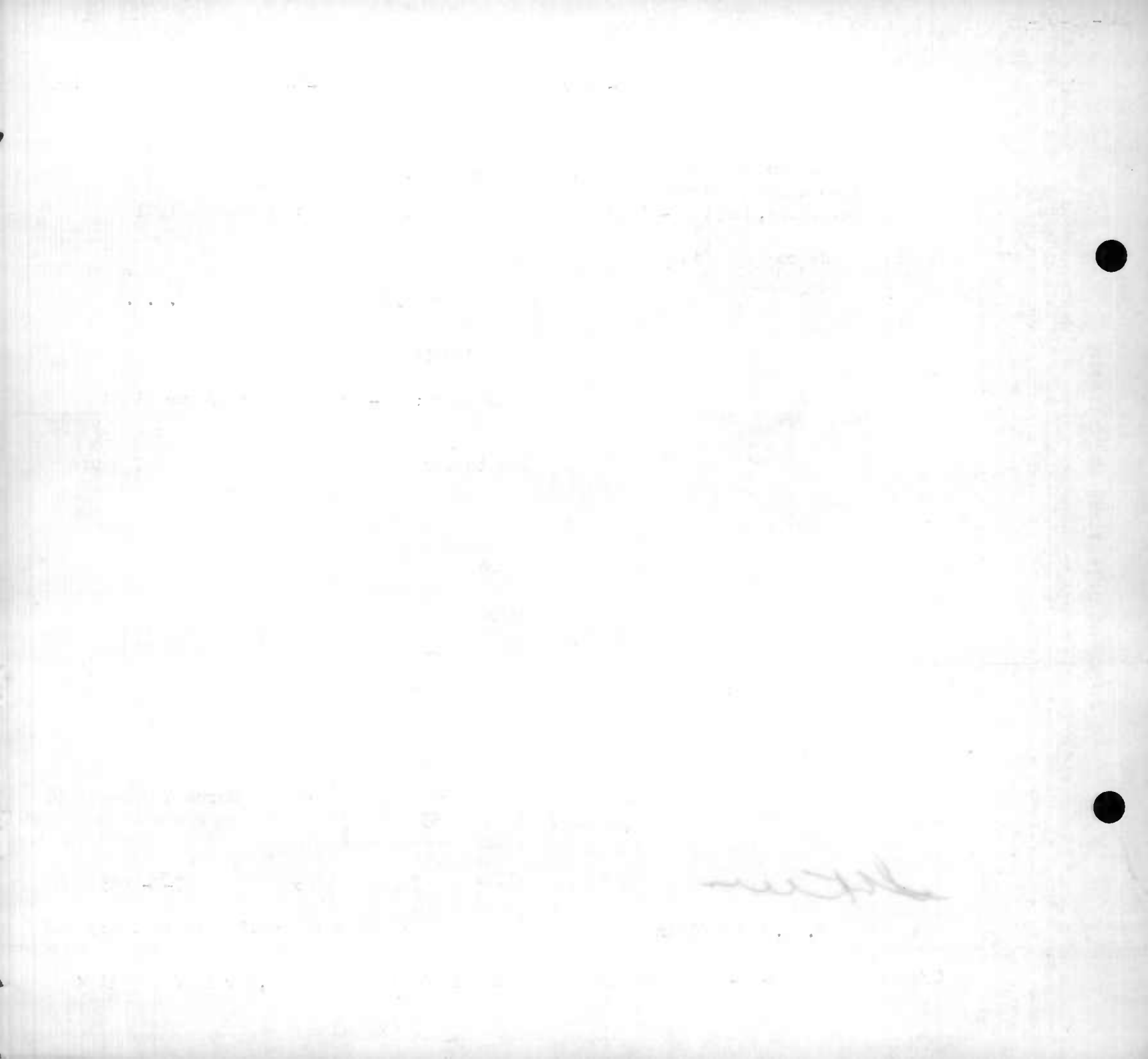
ADDRESS

VALLEY HOSPITAL

Blank

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

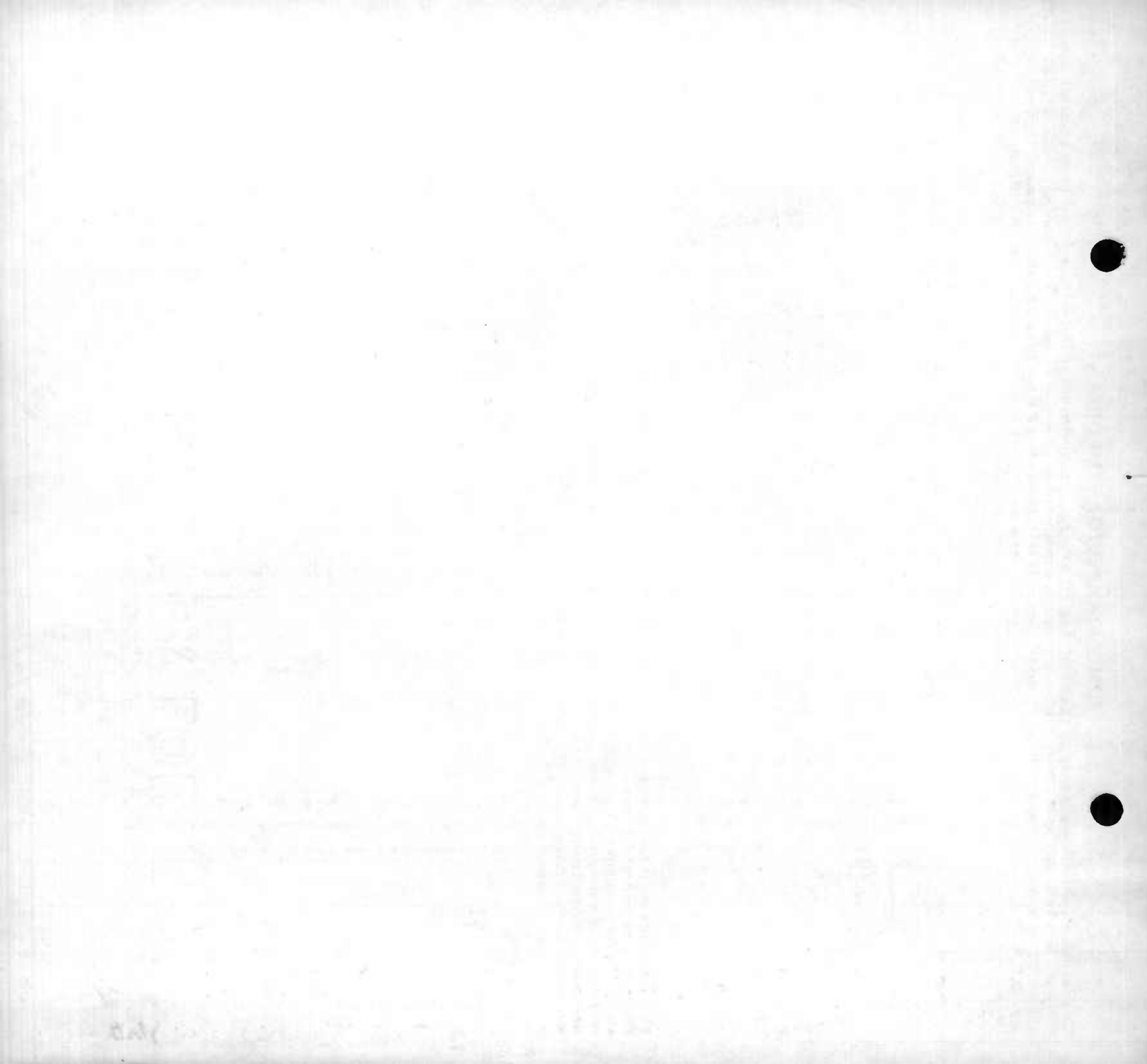
BIRTH NO. 65 2741				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 65 2741			
1. NAME OF DECEASED (Type or Print) <b>Baby Girl Coakley- Carrie</b>								2. DATE AND HOUR OF DEATH <b>3-7-1965 6:30A M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland-21224</b>								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>18-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>867 West Fairmount Avenue 21201</b>			
5. SEX <b>Female</b>		6. RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>		8. DATE OF BIRTH <b>3-6-65</b>		9. AGE (In years last birthday) <b>7</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME								14. MOTHER'S MAIDEN NAME <b>Carrie</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>					
18. <b>7768 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Immaturity</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.								CAUSE OF DEATH (A) <b>Immaturity</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>March 6 19 65</b> to <b>March 7 19 65</b> , that (I) (we) last saw the deceased alive on <b>March 7 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE 								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-7-1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. S. Wayne Klein</b>								23D. ADDRESS M.D. <b>4940 Eastern Avenue, Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremated</b>		24B. DATE <b>3-10-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore City Hospitals</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland 21224</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>				25C. FUNERAL DIRECTOR ADDRESS <b>2746</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2742		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 65 2742	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Olivia Wall</b>		2. DATE AND HOUR OF DEATH <b>MARCH 8<sup>th</sup> 1965 15:30 P</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>16-01</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>815 N. Carey Street - 21217</b>		D. STREET ADDRESS (If rural, give location) <b>815 N. Carey Street. 21217</b>			
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>JAN-12-1887</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Joseph Wall</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Flax</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-322-567</b>		17. INFORMANT ADDRESS <b>Mrs. Nellie Diggs Duvings Mills, Ind.</b>	
18. <b>43X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Hypostatus Pneumoniae</b> DUE TO		CAUSE OF DEATH <b>Hypertensive Cardiovascular Disease</b> DUE TO <b>Vasculodisease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 WK</b> <b>10 yrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/7/64</b> to <b>3/8</b> 19 <b>65</b> that (I) (we) last saw the deceased alive on <b>3/7/</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. Atwell Jones</b> M.D.				23B. DATE SIGNED <b>3/12/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>W. Atwell Jones</b>				23D. ADDRESS M.D. <b>554 Dolphin St Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/13/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Lukes Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Kidderstown, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Joseph L. Russ 2222 W. North Ave. 21216</b>			



# FUNERAL DIRECTOR: IMPORTANT

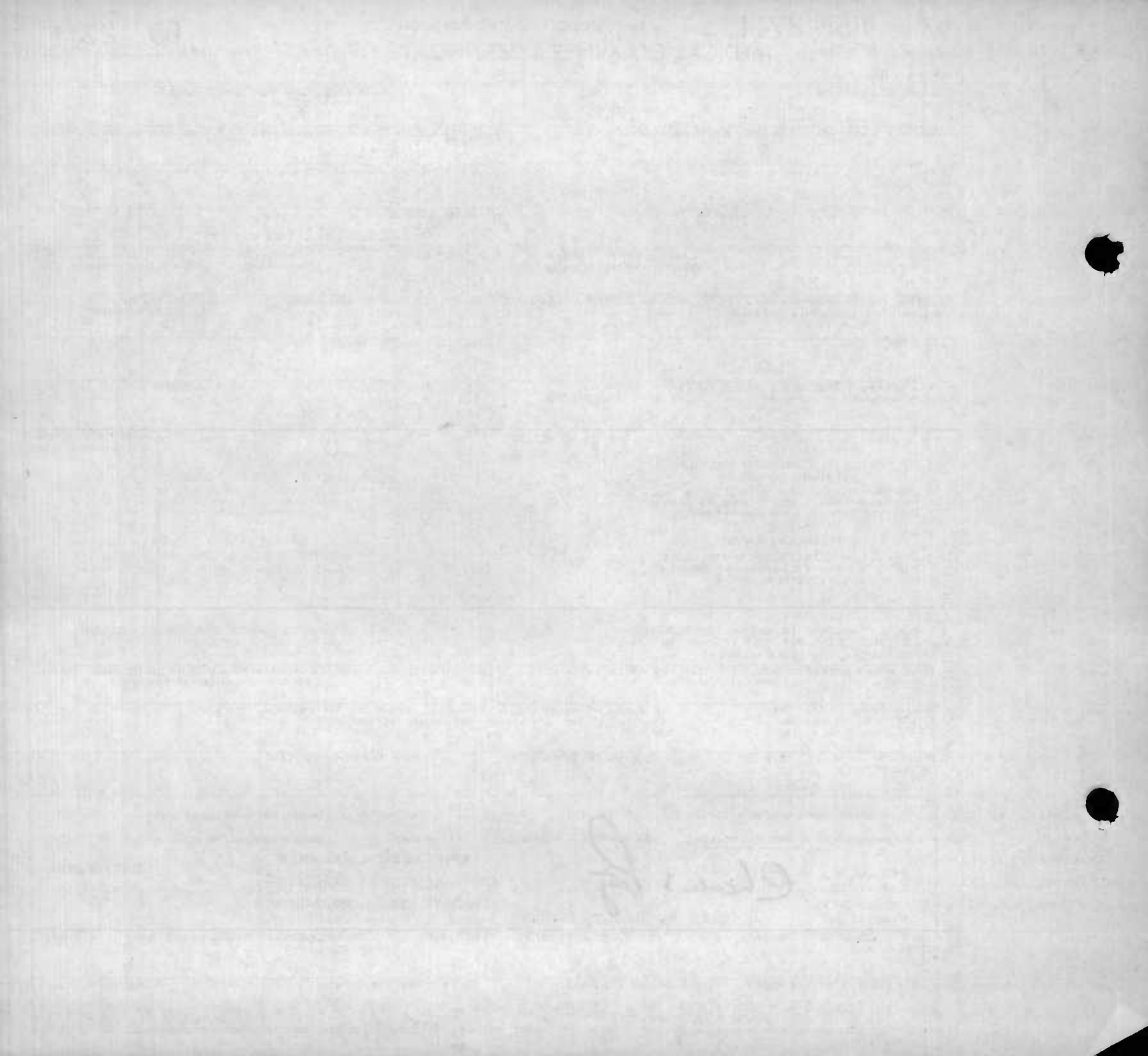
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2743		BALTIMORE CITY HEALTH DEPT.		Registered No. 65 2743	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LARRY LEE John HASSEL		2. DATE AND HOUR OF DEATH MARCH 10, 1965 5:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 2701		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GEN. HOSPITAL		D. STREET ADDRESS (If rural, give location) 5023 Crosswood Ln. Crosswood			
5. SEX M	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 8-24-58	9. AGE (In years lost birthday) 6	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME XXXXXXXXXXXXXXXXXXXX H. GORDON THOMAS		14. MOTHER'S MAIDEN NAME XXXXXXXXXXXX RITA FRANCES STANIEWSKI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS H. Gordon Thomas - same	
18. 75-4-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH CONGENITAL HEART DISEASE 6 years		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) Teaches - Bronchitis acute 12 hrs, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 59 to March 10 1965, that (I) (we) last saw the deceased alive on March 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hans J. Koetter		M.D. Attending Phys. Med. Director Staff Phys.		23B. DATE SIGNED March 10, 65	
23C. PHYSICIAN'S NAME (Type) HANS J. KOETTER		23D. ADDRESS 5600 Harford Road # 21214			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/11/65		24C. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL PARK	
24D. LOCATION BALTIMORE, MD.					
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1965		25B. NAME OF REGISTRAR Robert E. Stachura		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD.	









# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2745</u>	
BIRTH NO. <u>4-65 2745</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>7W.</u>		1. NAME OF DECEASED (Type or Print) <u>Bertha Hughes</u>		2. DATE AND HOUR OF DEATH <u>March 10, 1965</u> <u>4:00 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE CORRECTED</b> <u>4-2-65</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>6111 Shipview Way</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>7-20-92</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry Bracke</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>2/6-03-3378</u>		16. SOCIAL SECURITY NO. <u>2/6-03-3378</u>		17. INFORMANT ADDRESS <u>RECORDS: BCH 4940 Eastern Avenue 21224</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>II</u> <u>Diabetic Alidosis Cerebral Vascular Accident</u>		(A) <u>Meningitis</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Diabetes Mellitus</u> DUE TO		<u>10 years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 7, 1965</u> to <u>March 10, 1965</u> , that (I) (we) last saw the deceased alive on <u>March 10, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert Cooke</u>		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3-10-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert Cooke</u>		23D. ADDRESS M.D. <u>4940 Eastern Avenue 21224</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/15/65</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Mary's</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1965</u>		24F. NAME OF REGISTRAR <u>Robert E. Jackson</u>	
24G. FUNERAL DIRECTOR <u>W. B. W. 4101 E. dmonson</u>		24H. ADDRESS <u>4101 E. dmonson</u>			

Letter from B.C.H.

4-2-65

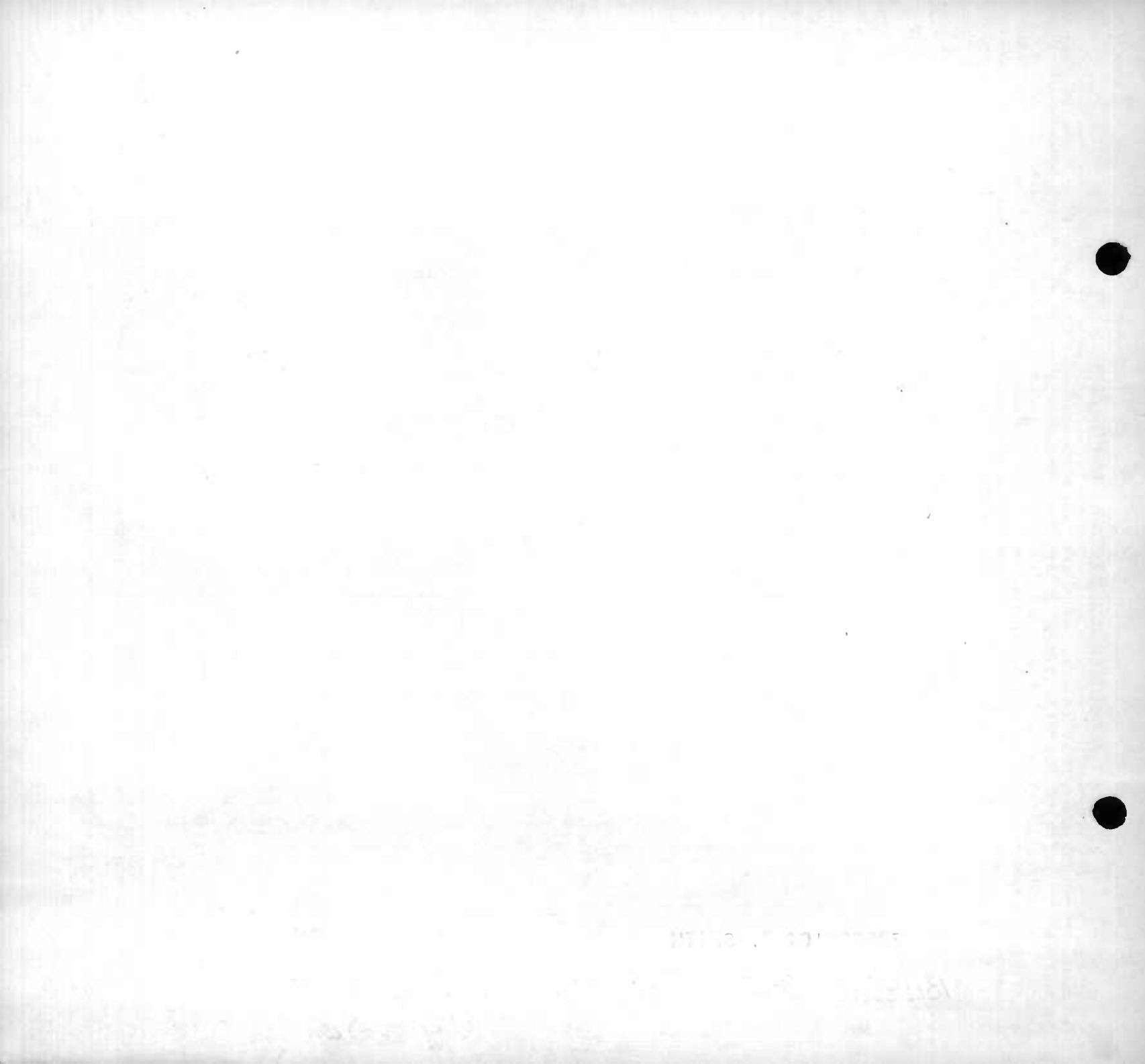
M.H.



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 2746			
BIRTH NO. 65 2746													
M.E. CASE NO.													
1. NAME OF DECEASED (Type or Print) <u>CELFSTE IDA HUGHES</u>						2. DATE AND HOUR OF DEATH <u>9 MARCH 1965</u> <u>6 40</u> P. M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>							
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>							
(If not in hospital or institution, give street address or location)						D. STREET ADDRESS (If rural, give location) <u>2639 BOONE STREET BOONE ST.</u>							
5. SEX <u>F</u>		6. RACE <u>NEGRO</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>11-7-04</u>		9. AGE (In years last birthday) <u>60</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>SERVICE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>HORACE HARRIS</u>						14. MOTHER'S MAIDEN NAME <u>ALICE GASAWAY</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>N/A</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MRS. DAVIS</u>				ADDRESS <u>2644 BOONE STREET</u>			
18. <u>120X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) DUE TO <u>Carcinoma of mammary gland 7 metastases to regional lymph nodes</u> (B) DUE TO <u>liver and peritoneal</u> (C) <u>surpises</u>						INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>NONE</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>				20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>N/A</u>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>N/A</u>				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>N/A</u>					
21D. TIME OF INJURY (APPROX.) <u>N/A</u>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> <u>N/A</u> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? <u>N/A</u>					
22. I certify that (I) (this hospital) attended the deceased from <u>3-2-65</u> 19 to <u>3-9-65</u> 19, that (I) (we) last saw the deceased alive on <u>3-9-65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE <u>FREDERICK O. SMITH</u> M.D.										23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <u>FREDERICK O. SMITH</u>										23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-13-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Em Balto</u>				24D. LOCATION (City, town, or county) (State) <u>MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1965</u>				25B. NAME OF REGISTRAR <u>Robert E. Fisher M.D.</u>				25C. FUNERAL DIRECTOR <u>Raymond Sanders</u>					
ADDRESS <u>217 E. Preston St</u>													





65 2747		BALTIMORE CITY HEALTH DEPARTMENT		65 2747	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.					
BIRTH NO.					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
EDWARD Barnum CATLING			March 13, 1965 10:20 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Mercy Hospital			Maryland Baltimore		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
			Towson re 53-00		
			D. STREET ADDRESS (If rural, give location)		
			204 E. Joppa Road 4		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	White	Married	2/22/1897	68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Supervisor		Gas & Electric Co.		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Leonard Catling			Ruth S. Shaw		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes World War I		212-05-3579		204 East Joppa Road	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) Arteriosclerotic Cardiovascular Disease. DUE TO  (B) DUE TO  (C) DUE TO	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
Charles S. Petty, M.D.			ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
Burial		3/16/1965	Druid Ridge Cemetery	Pikesville, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
MAR 15 1965		Robert E. Taylor		Baltimore, Md. 21217	

VALLEY FORGE

MARKED ON THE

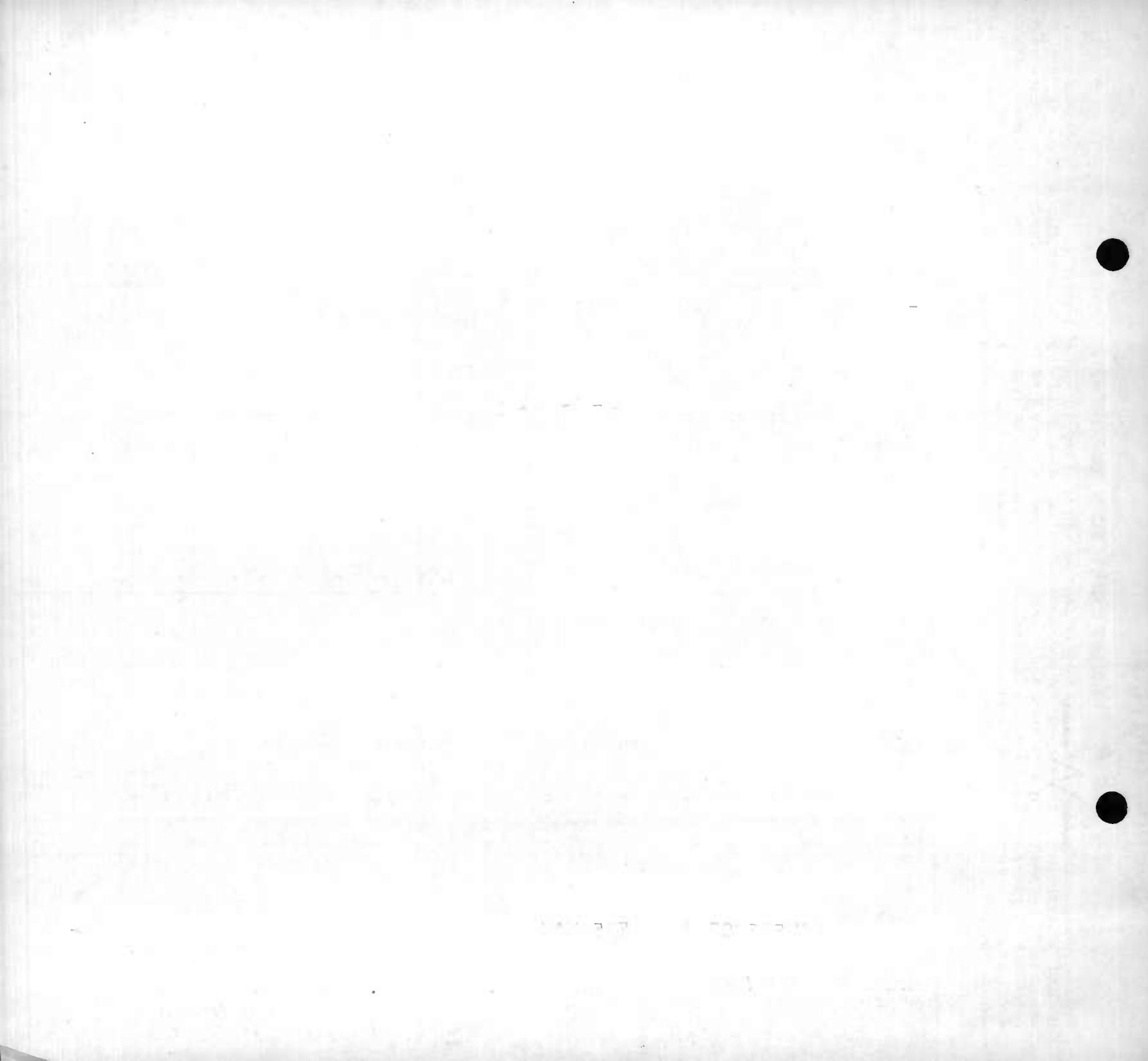
PLAN

Class 1/2

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

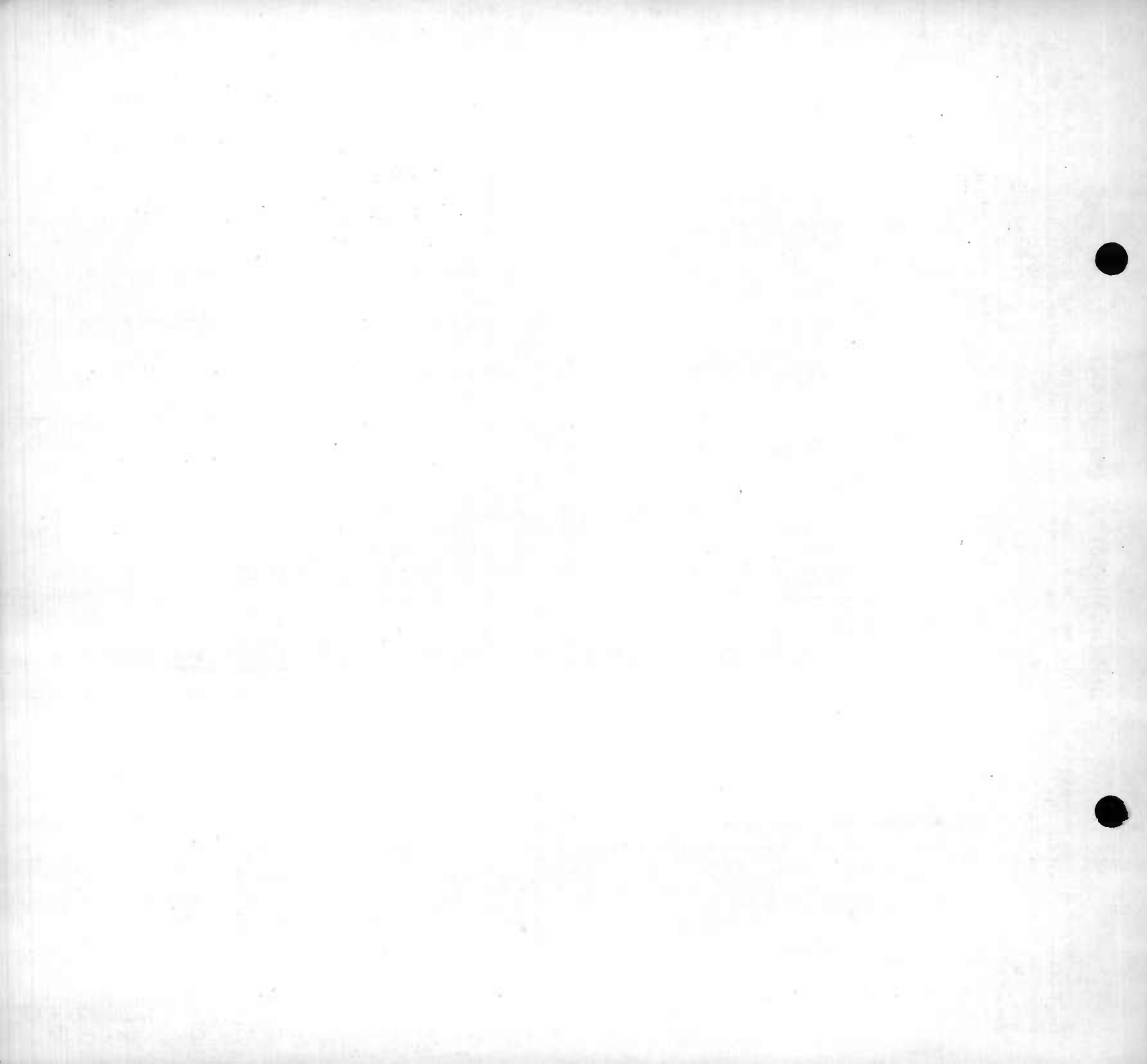
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2748	
BIRTH NO. 65 2748		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Theodore R. Hessinger</i>		2. DATE AND HOUR OF DEATH <i>3-13-65 10<sup>40</sup> P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>9-02</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1652 Shady Side Rd</i> <i>18</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>9-1-00</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self-employed</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Auto Mechanic</i>		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William P. Hessinger</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Boyd</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-20-2641</i>		17. INFORMANT <i>Chart - Union Memorial Hosp</i>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of the Lung</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>radiated</i> <i>Bi lateral confluent bronch pneumonia</i> <i>GI Hemorrhage, acute from Gastric stoma</i>		CAUSE OF DEATH <i>Carcinoma of the Lung</i> <i>radiated</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 month</i> <i>5-6 days</i> <i>Acute</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (A) (this hospital) attended the deceased from <i>3-4</i> <i>1965</i> to <i>3-13</i> <i>1965</i> , that (B) (we) lost saw the deceased alive on <i>3-13</i> <i>1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (C) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Lawrence J. Lieberman</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3-13-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>LAWRENCE J. LIEBERMAN</i>		23D. ADDRESS <i>M.D.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/17/1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Mem. Park Cemt.</i>	
24D. LOCATION (City, town, or county) (State) <i>Elkridge, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wm. J. ...</i>			
25D. ADDRESS <i>Balto. Md. 21217</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2749		CERTIFICATE OF DEATH		Registered No. 65 2749	
1. NAME OF DECEASED (Type or Print) <i>Warfield, Helen Virginia</i>				2. DATE AND HOUR OF DEATH <i>March 13, 1965 5:30 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Franklin Square Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>28-04</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>702 Nottingham Road 21229</i>					
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWER, <input type="checkbox"/> DIVORCED (specify)		8. DATE OF BIRTH <i>7/28/1889</i>		9. AGE (in years last birthday) <i>75</i>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Edward G. Rupp</i>				14. MOTHER'S MAIDEN NAME <i>Mamie Benjamin</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Helen Winghester</i>		ADDRESS <i>1631 Benfield Rd. A.A. Co.</i>			
18. <i>420.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Arteriosclerotic Heart Disease</i> DUE TO (B) <i>Cerebral thrombosis</i> DUE TO (C) <i>Atrial fibrillation</i>				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>3/13/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>2:00 PM 3/13</i> 19 <i>65</i> to <i>5:30 AM 3/13</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>5:30 AM March 13</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Kyo Rak Lee</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <i>Kyo Rak Lee</i>				23D. ADDRESS <i>Franklin Square Hosp.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/16/1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wm. J. Johnson &amp; Son</i>		ADDRESS <i>Balto. Md. 21217 North Pa. Ave.</i>			

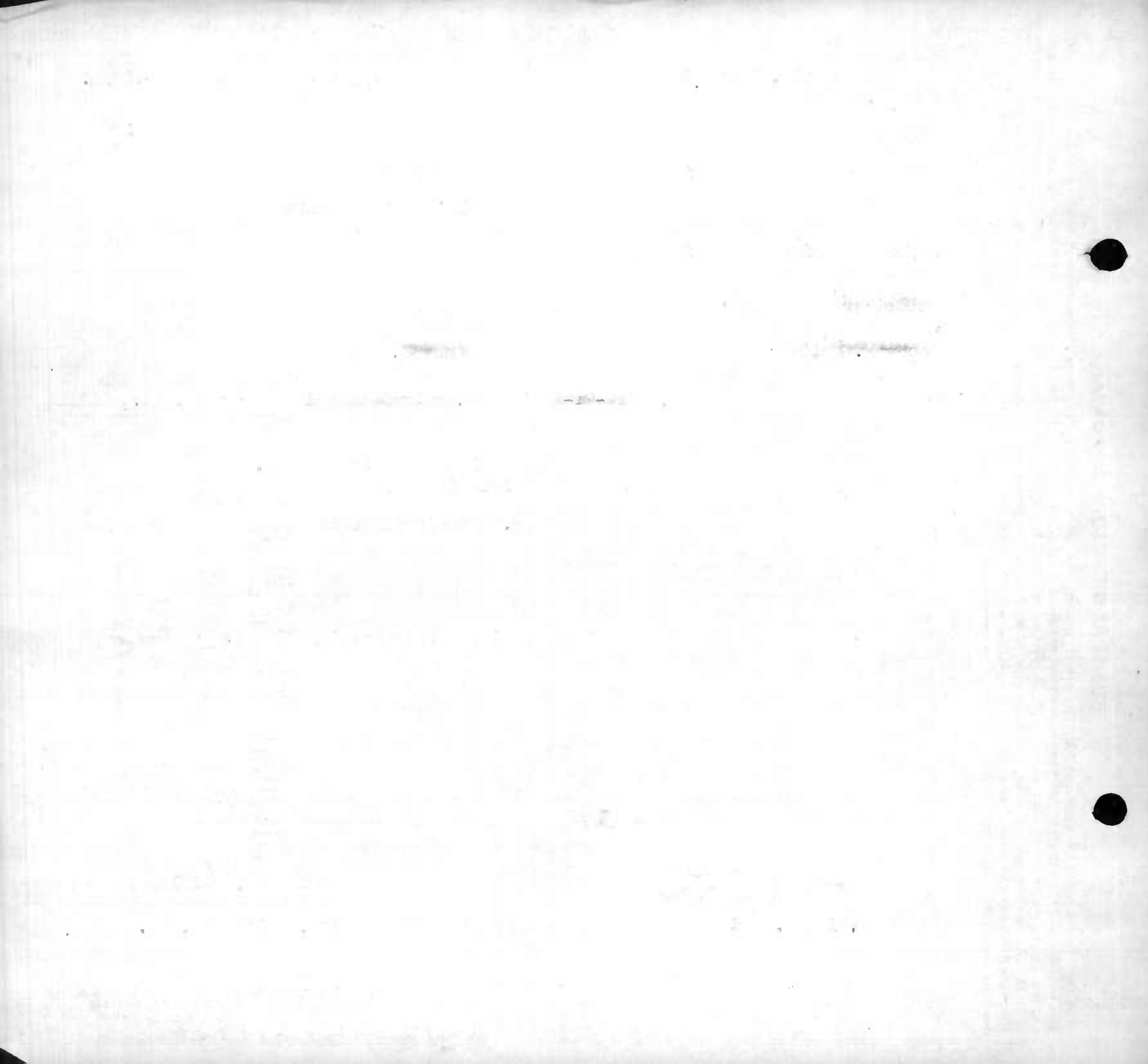


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BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 2750					CERTIFICATE OF DEATH			Registered No. 65 2750	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Dyke, Mary Gladys					2. DATE AND HOUR OF DEATH 3/13/65 6:00 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Montebello State Hospital					A. STATE Maryland B. COUNTY 13-08				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					D. STREET ADDRESS (If rural, give location) 1601 Union Avenue				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH 8/21/1890	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milliner			10B. KIND OF BUSINESS OR INDUSTRY Manufacturing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John F. Reid					14. MOTHER'S MAIDEN NAME Anne E. Porter				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-01-2405		17. INFORMANT 1601 Union Avenue Address Mrs. Elizabeth Reid Baltimore, Md. 21211				
18. 332X I CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					(A) Cerebral thrombosis with rt. Hemiplegia				
ANTECEDENT CAUSES					(B) Gen. Arteriosclerosis				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive cardiovascular disease					Unknown				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1/26/65 19 to 3/13/65 19, that (I) (we) last saw the deceased alive on 3/13/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Daniel G. Lai					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 3/13/65	
23C. PHYSICIAN'S NAME (Print) Daniel G. Lai					23D. ADDRESS M.D. 2201 Argonne Drive, Baltimore, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/1965		24C. NAME OF CEMETERY or CREMATORY Lake View Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. J. Tubney & Sons Balto., Md. 21217 ADDRESS 21217					

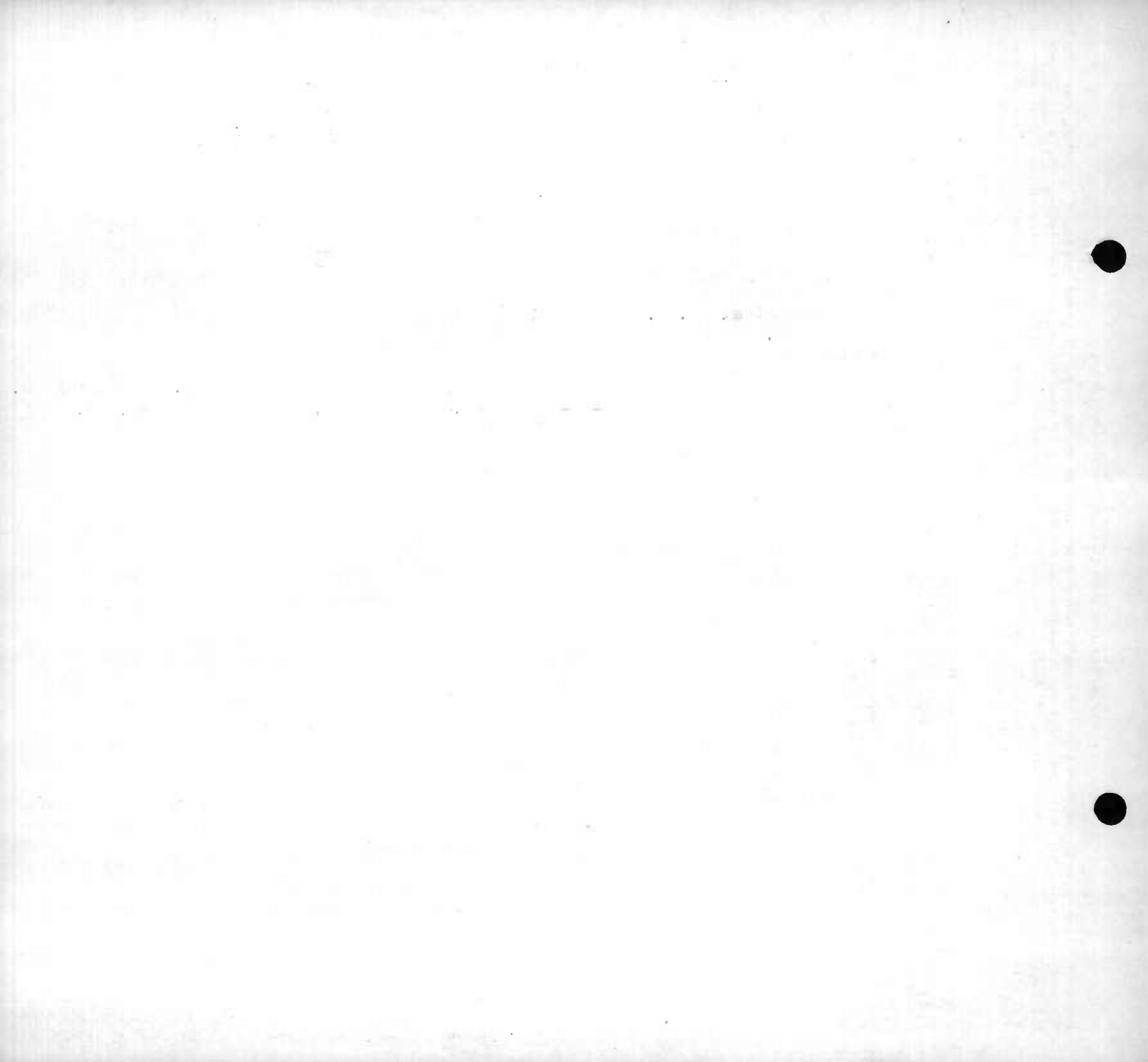




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Baltimore City and County Department of Health				Baltimore City and County Department of Health	
BIRTH NO.				Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>FOWBLE, XEROY Edward</b>			2. DATE AND HOUR OF DEATH <b>3-14-65</b> <b>2-30</b> <b>PM</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran hospital of Maryland.</b>			A. STATE <b>MD.</b> B. COUNTY <b>2804</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>8.8. Woodington Rd.</b> <b>21229</b>		
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>7-29-1914</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer mechanical</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Benzoniam Fawble</b>			14. MOTHER'S MAIDEN NAME <b>mamie arington</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b> <b>None</b>			16. SOCIAL SECURITY NO. <b>214-18-7504</b>		17. INFORMANT <b>Mrs. Katherine R. Fowble Baltimore, Md.</b> <b>21229</b>
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>massive C.I. bleeding</b> DUE TO (B) <b>Acute myocardial infarction</b> DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-13</b> <b>1965</b> to <b>3-14</b> <b>1965</b> , that (I) (we) last saw the deceased alive on <b>3-14</b> <b>1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>G.H. Adib M.D.</b>				23B. DATE SIGNED <b>3-14-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>G.H. Adib M.D.</b>				23D. ADDRESS <b>Lutheran hospital.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/17/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>		25C. FUNERAL DIRECTOR <b>Wm. J. [unclear]</b>			
25D. ADDRESS <b>Baltimore, Md. 17</b>		25E. ADDRESS <b>North &amp; Pa. aves.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2752				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2752	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Isabel S. Hollingsworth				2. DATE AND HOUR OF DEATH March 13, 1965 10 <sup>30</sup> PM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 103 Croydon Road Baltimore, Maryland 21212				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 103 Croydon Road 21212			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 7/25/1888	9. AGE (in years last birthday) 76	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Daniel Shamberger				
14. MOTHER'S MAIDEN NAME Martha Jane Smith			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None				
16. SOCIAL SECURITY NO. 167-10-5230			17. INFORMANT ADDRESS Mrs. C. Edwin Fitzell Baltimore, Md. 21212				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS SUDDEN				INTERVAL BETWEEN ONSET AND DEATH 12 YRS.			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HYPERTENSIVE HEART DISEASE 12 YRS.				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/2/53 19 to 3/13 1965, that (I) (we) last saw the deceased alive on 3/13/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Stuart D. Sunday				23B. DATE SIGNED 3/15/65			
23C. PHYSICIAN'S NAME (Type) STUART D. SUNDAY				23D. ADDRESS 201 E- 39th St - (18)			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 3/16/1965		24C. NAME of CEMETERY or CREMATORY Loudon Park Crematory		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. J. Tipton & Son		25D. ADDRESS Baltimore, Md. 17 North & Penn. Aves.	



5-300

65-00489  
65 2753

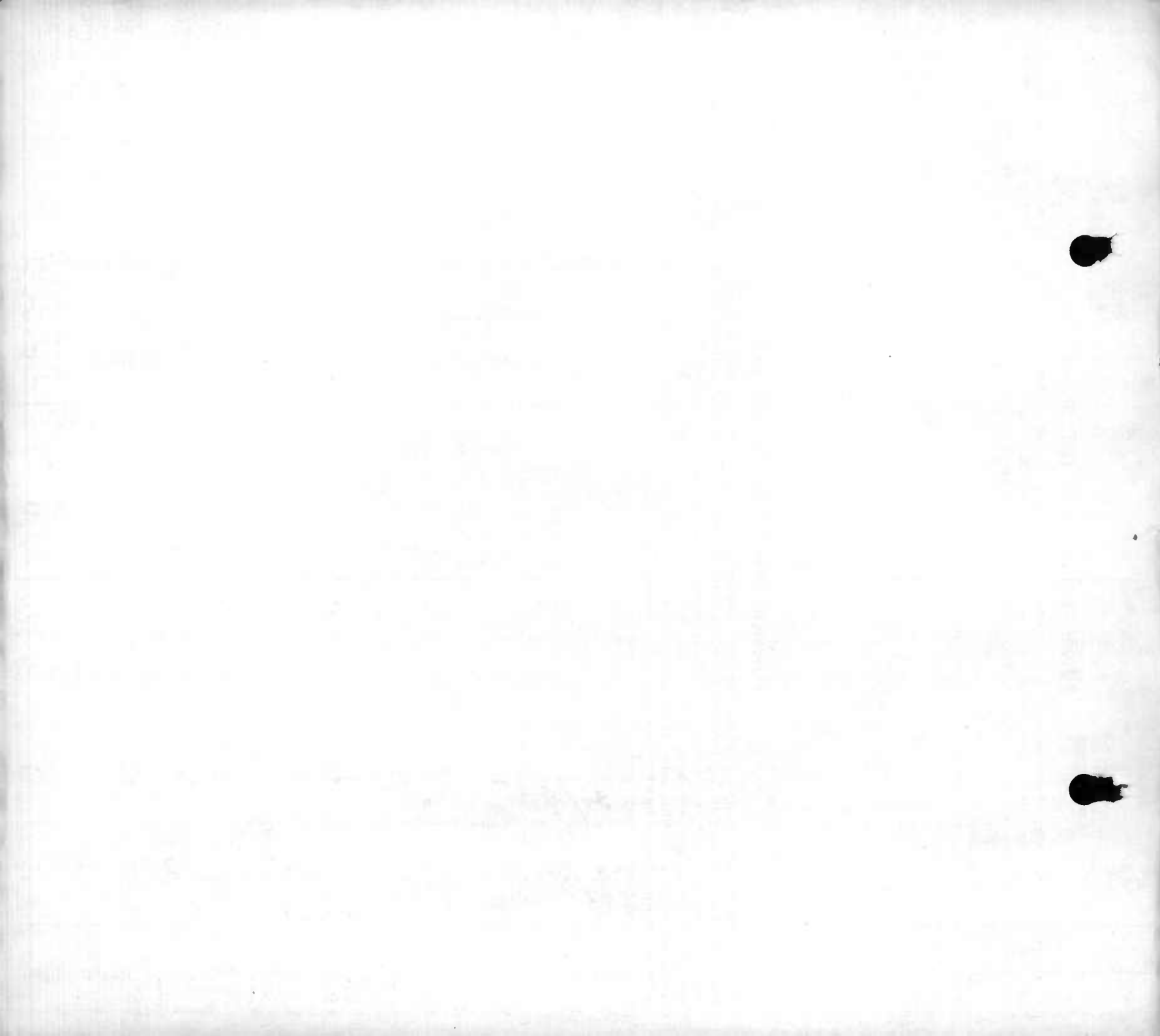
# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 65 2753

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Baby Boy Scott</i>		2. DATE AND HOUR OF DEATH <i>3-9-65 2:30 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Mercy Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>18-01</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>44 N. Poppleton St.</i>			
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Newborn</i>		8. DATE OF BIRTH <i>3-9-65</i>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <i>1-5m</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Daniel Scott</i>				14. MOTHER'S MAIDEN NAME <i>Joyce Lorraine Jackson</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <i>773.51</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO <i>Hyaline Membrane Lesion</i> (B) DUE TO <i>Immaturity</i> (C) DUE TO <i>Preterm Labor</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Placental Abruption</i>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>2:55 P.M. 3/9/65</i> to <i>3:00 P.M. 3/9/65</i> , that (I) (we) last saw the deceased alive on <i>3/9/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Ernest Sammis, Jr.</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>3/9/65</i>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>Johns Hopkins Medical School</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>MAR 15 1965</i>		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS		25D. MORTUARY SERVICE - BCD	

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

DELE DUZ

2. DATE AND HOUR PRONOUNCED DEAD

February 25, 1965 3:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

613 E. Baltimore Street

5. SEX  
Male6. RACE  
White7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)  
50If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 422.1 I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular  
DUE TO disease

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?  
Yes21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-26-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

MAR 15 1965

23C. NAME of CEMETERY or CREMATORY

ANATOMY BOARD MARYLAND

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

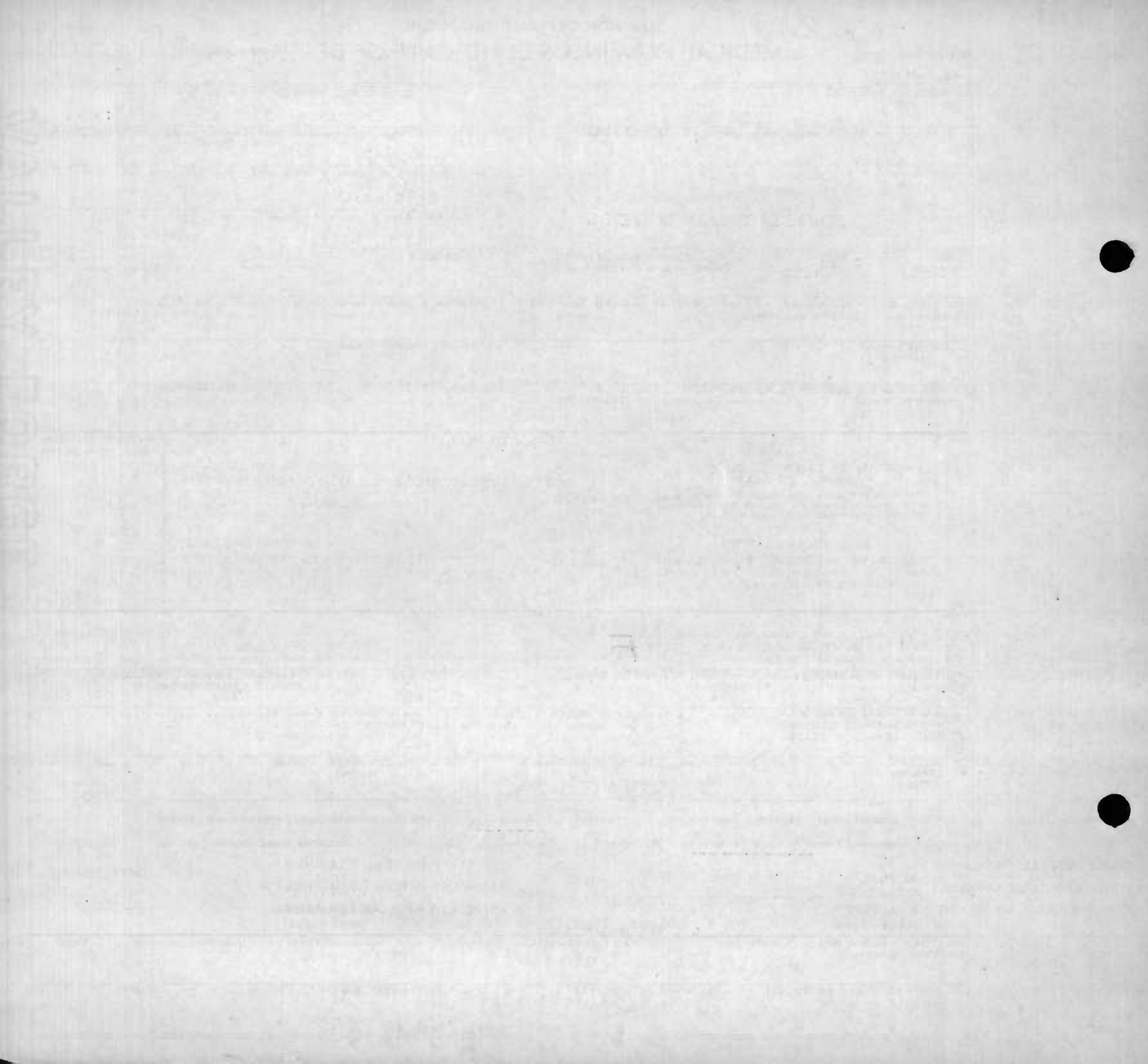
24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

UNIVERSITY MEDICAL SCHOOL

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>65-04988</b>		65 2755		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Watkins, Baby Boy</b>		2. DATE AND HOUR OF DEATH <b>3-5-65 11<sup>15</sup> AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Int'l Harp of Md.</b>		A. STATE <b>Maryland</b>		B. COUNTY <b>Baltimore</b>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
		<b>26 S. Exeter Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Colo</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>3-1-65</b>	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
		<b>Int'l Harp of Md</b>	<b>U.S.A.</b>		
13. FATHER'S NAME <b>Edward Watkins</b>		14. MOTHER'S MAIDEN NAME <b>Timmons, Dorothy</b>		ADDRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
18. <b>728.51</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Septicemia</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10:20 AM</b> to <b>1:10 AM</b> 19 <b>65</b> to <b>5th March</b> 19 <b>65</b> .		that (I) (we) last saw the deceased alive on <b>1:10 AM</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>In Bal</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>Int'l Harp of Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>MAR 9 1965</b>		24C. NAME OF CEMETERY OR CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65-04985					65 2756				
CERTIFICATE OF DEATH									
M.E. CASE NO.					Registered No.				
1. NAME OF DECEASED (Type or Print) <i>Baby Boy Buckingham</i>					2. DATE AND HOUR OF DEATH <i>3/3/65 6:45 PM</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital of Md.</i>					A. STATE <i>906 Madison Ct Balto</i>				
(If not in hospital or institution, give street address or location)					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 24, MD. 53-00</i>				
					D. STREET ADDRESS (If rural, give location)				
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>3/2/65</i>		9. AGE (In years last birthday) <i>40</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>M.D.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
13. FATHER'S NAME <i>John Buckingham</i>					14. MOTHER'S MAIDEN NAME <i>Delawder, Loretta</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>760.51</i>					CAUSE OF DEATH (A) DUE TO <i>cerebro-spinal hemorrhage</i> (B) DUE TO <i>prematurity</i> (C) _____				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>2/2</i> 19 <i>65</i> to <i>3/3</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>3/3</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Assessors</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>3/3/65</i>	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>MAR 9 1965</i>		24C. NAME OF CEMETERY OR CREMATORY <i>ANATOMY BOARD OF MARYLAND</i>		24D. LOCATION (City, town, or county)		(State)	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Jones</i>		25C. FUNERAL DIRECTOR <i>UNIVERSITY MEDICAL SCHOOL</i>		ADDRESS <i>MORTUARY SERVICE - BCHO</i>			

Letter to the Editor

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Letter to the Editor  
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Letter to the Editor

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65 2757

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 65 2757

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

William Waters

2. DATE AND HOUR OF DEATH

March 10, 1965

7:49 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1602 W. Franklin Street 21223

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

6-5-1915

9. AGE (In years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

GREENWOOD WATERS

14. MOTHER'S MAIDEN NAME

LILLIE PLATER

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18. 493X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Pneumonia  
DUE TO

4-5 Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 10, 1965 to March 10, 1965

that (I) (we) last saw the deceased alive on March 10, 1965 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C. M. Cooke

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

March 10, 1965

23C. PHYSICIAN'S  
NAME (Type)

Robert Cooke

M.D.

4940 Eastern Avenue 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

3/10/65

24C. NAME of CEMETERY or CREMATORY

ARBURUS MEM. PARK ARBORUS BALTO. G. MD

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

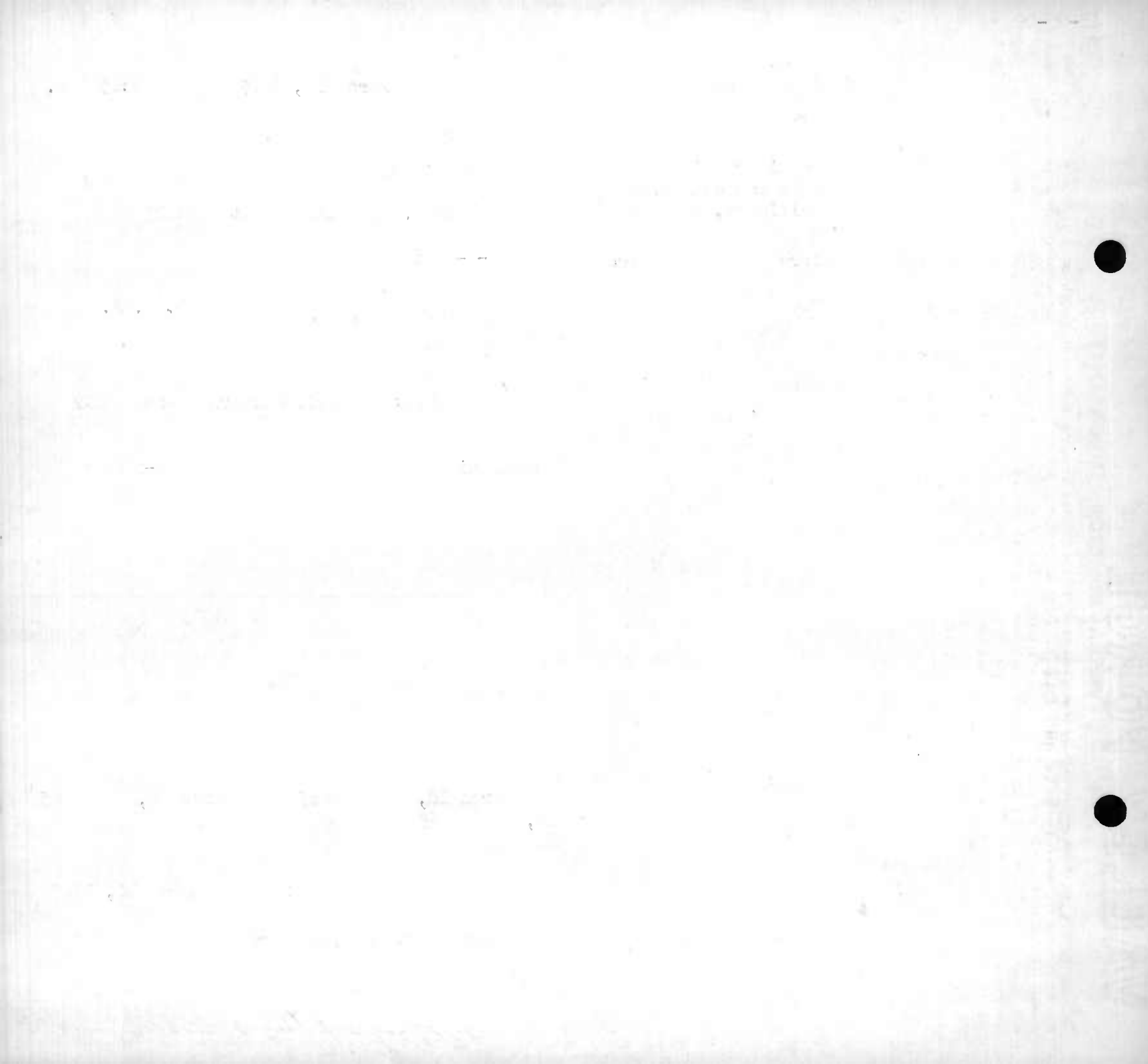
M. J. Hayes 638 N. G. Street

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

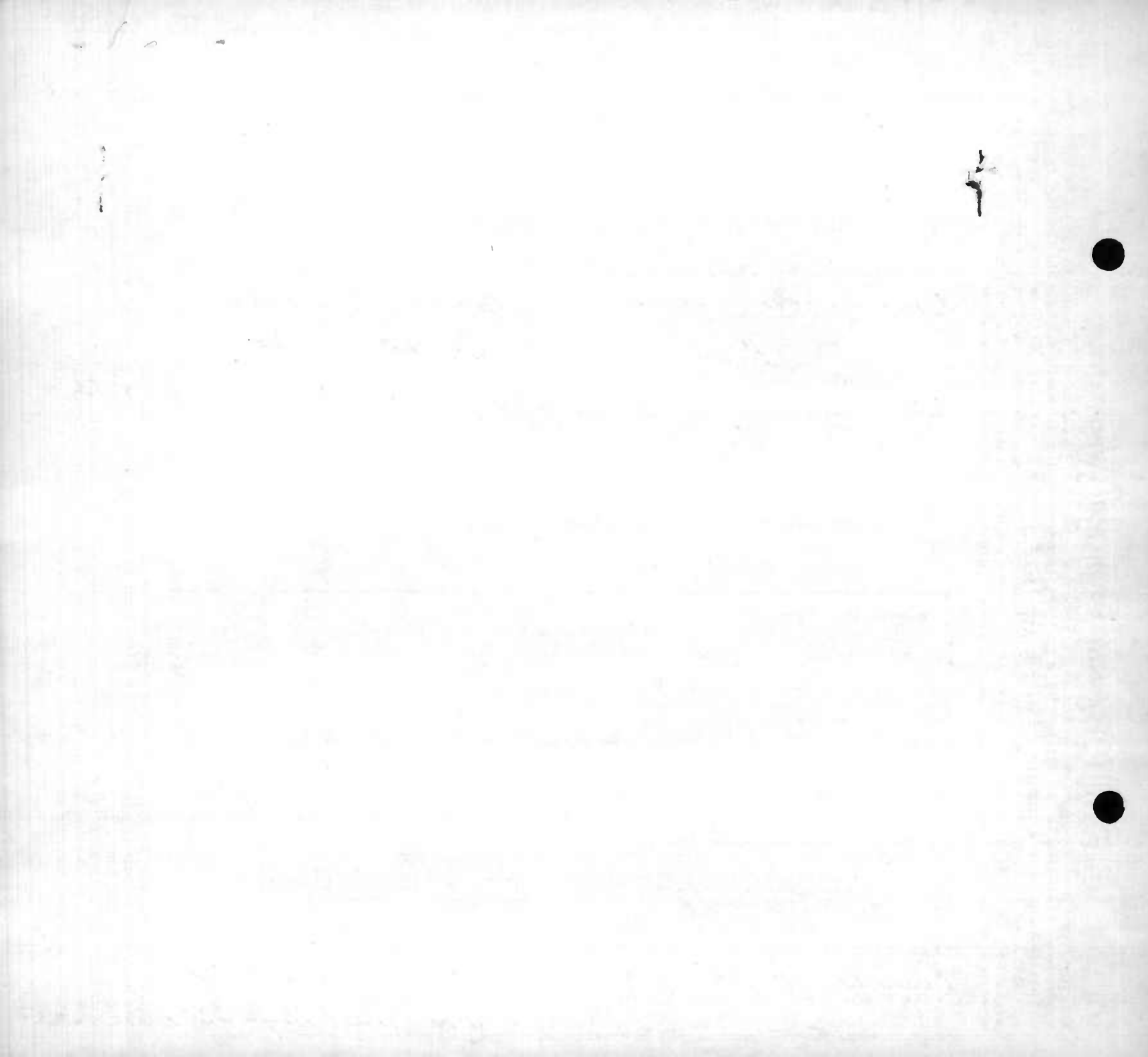




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2758				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2758	
1. NAME OF DECEASED (Type or Print) <u>Andella Chinn</u>				2. DATE AND HOUR OF DEATH <u>3-13-65</u> <u>6<sup>44</sup></u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> 30 <u>25-33</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2608 PIERPONT AVE.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> , DIVORCED (specify)	8. DATE OF BIRTH <u>4-19-99</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHIRTMAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>HOWLANDS BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ellsworth Hill</u>			14. MOTHER'S MAIDEN NAME <u>SARAH CAMPER</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-03-1084</u>		17. INFORMANT <u>Edna Scott</u>		ADDRESS <u>2608 PIERPONT ST</u>	
18. <u>445X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Chronic</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic renal disease etiology U.K.</u> <u>Malignant hypertension</u>				CAUSE OF DEATH (A) <u>Chronic</u> DUE TO (B) <u>Chronic renal disease etiology U.K.</u> DUE TO (C) <u>Malignant hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>?</u> <u>?</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hypertension probably essential</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 20</u> 19 <u>65</u> to <u>March 13</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>March 13</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael G. Hayes</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3-13-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael G. Hayes</u>				23D. ADDRESS <u>Univ. Hosp., Univ. of Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/17/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Manly P. Hyatt</u>			
ADDRESS <u>638 N. GILMON ST</u>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2759		CERTIFICATE OF DEATH		Registered No. 65 2759	
1. NAME OF DECEASED (Type or Print) <b>EDWIN GAREIS Sr.</b>				2. DATE AND HOUR OF DEATH <b>3-14-65</b>   <b>9:58 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>705</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>616 N. CHESTER ST.</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>11-26-81</b>	9. AGE (In years lost birthday) <b>83</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MOVER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOHN GAREIS</b>				14. MOTHER'S MAIDEN NAME <b>AMELIA SCHULTZ</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Jerome J. Wheeler - 527 N. Fenwood Ave.</b>			ADDRESS		
18. <b>340.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>MENTINGITIS</b>				CAUSE OF DEATH (A) DUE TO <b>MENTINGITIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>PNEUMOCOCCAL EMPYEMA</b>		<b>3 WEEKS</b>			
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>? OCCULT NEOPLASM</b>		<b>1 YEAR</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>FEBRUARY 26, 1965</b> to <b>MARCH 14, 1965</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>MARCH 14, 1965</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Virgil Brown</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-14-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>VIRGIL BROWN</b>				23D. ADDRESS M.D. <b>THE JOHNS HOPKINS HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-17-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>		25B. NAME OF REGISTRAR <b>R. S. S. S. S.</b>		25C. FUNERAL DIRECTOR <b>W. J. Miller - 2334 Jefferson St.</b>		ADDRESS			

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BALTIMORE CITY HEALTH DEPARTMENT

65 2760

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT T. PORTER

2. DATE AND HOUR PRONOUNCED DEAD

March 12, 1965 4:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

617 St. Paul Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

10-1-1875

9. AGE (In years  
last birthday)

89

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

DETECTIVE

10B. KIND OF BUSINESS OR INDUSTRY

POLICE DEPT.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Winnie E. Porter - 803 N. Wynton Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Gunshot Wound of Head.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Hospital

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Mercy Hospital Accident Room

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
3 12 '65 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/13/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

3-16-65

23C. NAME of CEMETERY or CREMATORY

BALTIMORE CEM.

23D. LOCATION

(City, town, or county)

BALTO., Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

24B. NAME OF REGISTRAR

Robert E. Taylor M.D.

24C. FUNERAL DIRECTOR

Hester Miller - 2334 Jefferson St

ADDRESS

VALLEY FORDS

HAS CONTINUED

IN

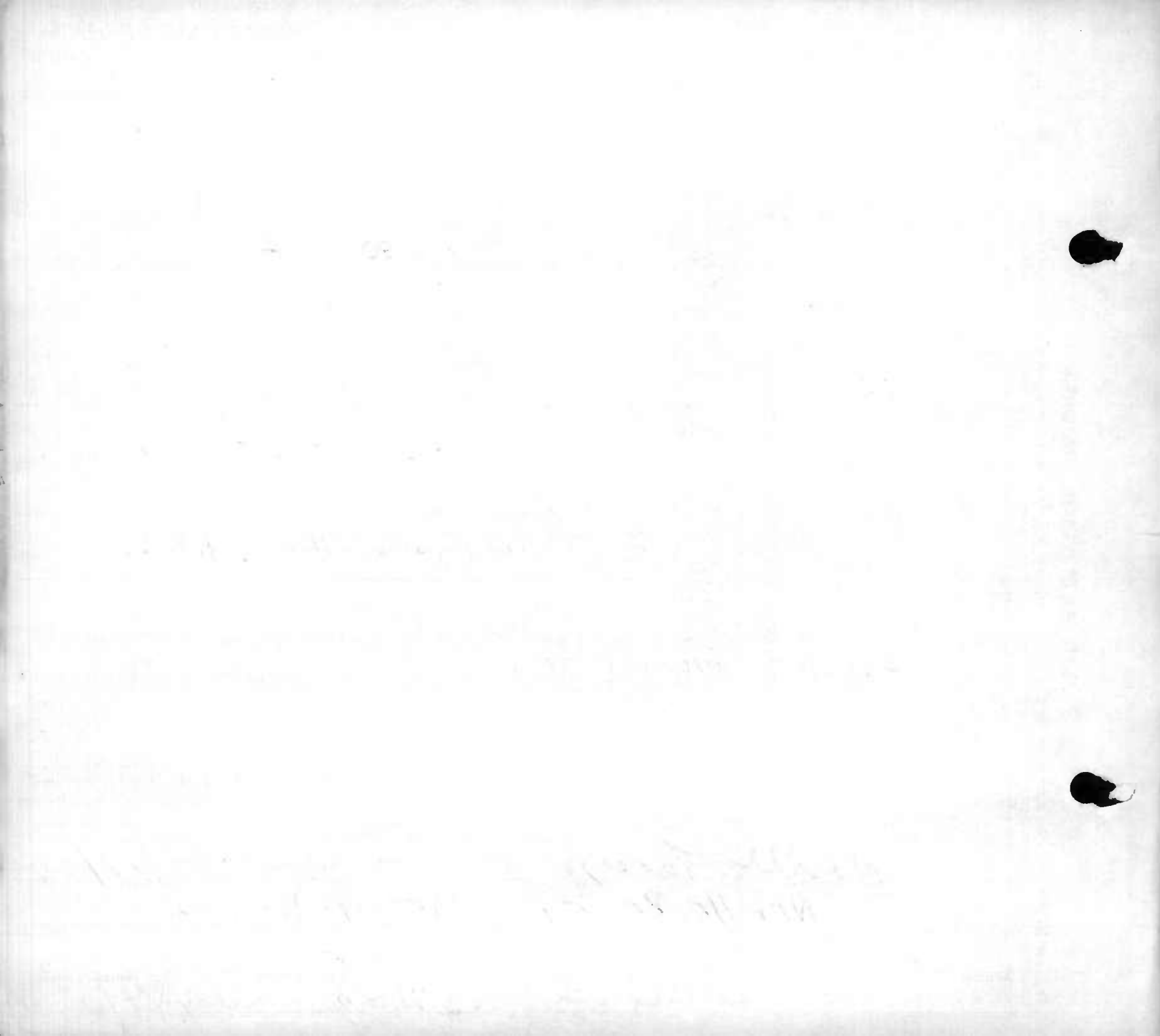
Class 1/2



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2761	
BIRTH NO. 65 2761		CERTIFICATE OF DEATH		Registered No. 65 2761	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Edmund J. Meisel</i>		2. DATE AND HOUR OF DEATH <i>3-14-65</i>   <i>2</i> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>7-03</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>720 N. Patterson Pk Ave</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy</i>		(If not in hospital or institution, give street address or location)			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>8-6-90</i>	9. AGE (In years lost birthday) <i>74</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CLERK</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Joseph Meisel</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Drautwein</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. Carolyn B. Sylvester - 1647 Covington St</i>		ADDRESS
18. <i>585X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>CARDIAL ARREST</i> DUE TO (B) <i>Kidney dis, chole cystitis</i> DUE TO (C) <i>Kidney dis, chole cystitis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>3/13/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>cholecystotomy</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/11/65</i> 19 to <i>3/14</i> 19 <i>6 p.</i> , that (I) (we) last saw the deceased alive on <i>3/13</i> 19 <i>6 p.</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Neville Pereyo</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/14/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>NEVILLE PEREYO</i>		23D. ADDRESS <i>MERCY HOSP.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>3-17-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>ST. MATTHEWS CEM.</i>	
24D. LOCATION <i>BALTO., Md.</i>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>St. John's - 2334 Jefferson St.</i>	
25D. ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 2762					CERTIFICATE OF DEATH					Registered No. 65 2762									
1. NAME OF DECEASED (Type or Print) <b>WILSON ARTHUR</b>										2. DATE AND HOUR OF DEATH <b>MARCH 12 1965 9:15 A.M.</b>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST AGNES HOSPITAL</b>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>AA</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>8047 HIGH POINT RD. #26</b>									
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>3-3-11</b>		9. AGE (In years last birthday) <b>54</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE OPERATOR</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>Koppen Co</b>					11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>					12. CITIZEN OF WHAT COUNTRY? <b>C</b>				
13. FATHER'S NAME <b>HOWARD</b>										14. MOTHER'S MAIDEN NAME <b>ANNA</b>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>218 01 0546</b>					17. INFORMANT ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS</b>									
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic C-V Disease</b>										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b> <b>? years</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>History of Rheumatic Fever x2</b>																			
19A. DATE OF OPERATION <b>0</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 11 1965</b> to <b>MARCH 12 1965</b> , that (I) (we) last saw the deceased alive on <b>MARCH 12 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <b>MORSTON A. YOUNG</b>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <b>MARCH 12, 1965</b>				
23C. PHYSICIAN'S NAME (Type) <b>MORSTON A. YOUNG</b>										M.D. 23D. ADDRESS									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>3-16-65</b>					24C. NAME OF CEMETERY or CREMATORY <b>Landon Park</b>					24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>					25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>					25C. FUNERAL DIRECTOR <b>McCally Funeral Home 2376 Catonsville</b>					ADDRESS				

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65 2763

BALTIMORE CITY HEALTH DEPARTMENT

65 2763

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
JOHN A. JASCHIK		3/11/65 4:55 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland	
South Baltimore General Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 4141 Audrey Ave.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
male	white	Married	Jan 3, 1914
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday)
Laborer			51
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Balto, MD.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
George Jaschik		Mary Lamb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
Yes WW II		24-07-2485	Fam. by
		ADDRESS Same	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
Hypertensive cardiovascular disease			
(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
(B) DUE TO			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
Obesity			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED	
Werner U. Spitz, M.D.		3/12/65	
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	3-15-65	Green Haven Cem	Allen Burial md
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAR 15 1965	Robert E. Taylor, M.D.	McGilly Funeral Home	2376 Popescoe

2763

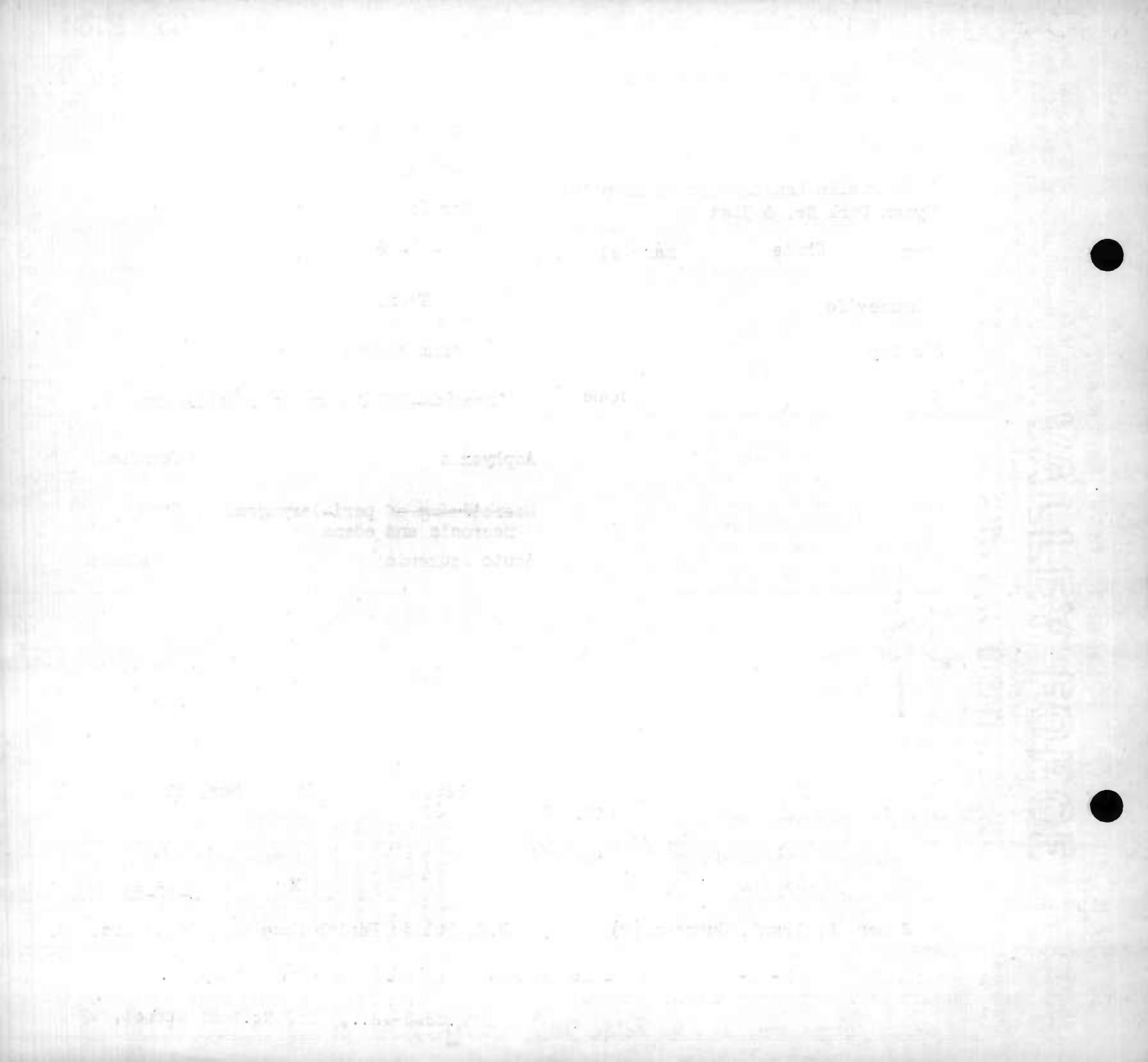
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2764</b>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 2764</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>UNDERWOOD, Eva Gertrude</b>				2. DATE AND HOUR OF DEATH <b>March 12, 1965 10:45 A. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>U.S. Public Health Service Hospital Wyman Park Dr. &amp; 31st St.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>West Virginia</b> B. COUNTY <b>✓-13</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Bradley</b> D. STREET ADDRESS (If rural, give location) <b>Box 65</b>			
5. SEX <b>Fem</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>11-27-06</b>	9. AGE (In years lost birthday) <b>58</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jim Ley</b>				14. MOTHER'S MAIDEN NAME <b>Anna Thomas</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>?</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>records-USPHS Hospital, Baltimore, Md.</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO <b>Asphyxia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Terminal</b>	
				(B) DUE TO <b>Neurotizing of peri-laryngeal necrosis and edema</b>		<b>Days</b>	
				(C) DUE TO <b>Acute leukemia</b>		<b>Unknown</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Feb. 9 19 65</b> to <b>Mar. 12 19 65</b> , that (I) (we) last saw the deceased alive on <b>Mar. 12 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Y) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>James H. Frank</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <b>3-12-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>James H. Frank, Surgeon (R)</b>				23D. ADDRESS M.D. <b>U.S. Public Health Hospital, Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24B. DATE <b>3-12-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Blue Ridge Memorial Gardens</b>		24D. LOCATION (City, town, or county) (State) <b>Raleigh County, W.Va</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook - Inc. 1217 St. Paul Street, 21202</b>			





B-620

BALTIMORE CITY HEALTH DEPARTMENT				65 2765			
BIRTH NO.				MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2765			
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)		HARRIETT M. BERK		2. DATE AND HOUR PRONOUNCED DEAD		March 12, 1965 10:42 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION  Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland			
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		Baltimore		21210 12-01	
		D. STREET ADDRESS (If rural, give location)		116 W. University Parkway			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
Female	White	widowed	Sept. 30, 1888	76			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
George S. Thornton		Harriett Tillson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		132-24-0283		Harry M. Thornton, 2623 Wendover Road, 21234			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  Arteriosclerotic Cardiovascular Disease. (A) DUE TO							
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (B) DUE TO							
III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  Fatty Liver and Early Cirrhosis. (C) DUE TO							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/13/65	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
BURIAL		3-16-65		Loudon Park Cemetery		Baltimore	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
MAR 15 1965		Robert E. Taylor, M.D.		Wm. Cook, Inc. 1217 St. Paul Street, 21202			

WALLER BROS

Class K

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2766</u>	
BIRTH NO. <u>65 2766</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Johnston, May Miller</u>		2. DATE AND HOUR OF DEATH <u>3/14/65 3 AM (Sun)</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND (MAY MILLER) JOHNSTON FULL NAME OF HOSPITAL OR INSTITUTION: <u>SOUTH BALTIMORE GEN. HOSPITAL</u> <u>1213 LIGHT STREET</u> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>23-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>11 E. WHEELING ST.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 31-1903</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George T. Miller</u>			14. MOTHER'S MAIDEN NAME <u>CAROLINE ST. Cyr</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>20-4194</u>		17. INFORMANT ADDRESS <u>Mrs. Mildred C. - 1428 S. 121230</u> <u>CIBOROSKI MANOR ST BALTO, Md.</u>	
18. <u>260X I</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <u>CTA (Cerebral Hemorrhage)</u> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Diabetic acidosis</u> DUE TO			
		(C) <u>Hypertension (severe)</u> <u>Pneumonia</u> <u>Urinary infection (E. coli)</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Q</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/16</u> 19 <u>65</u> <u>3/14</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>3/14</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Chung K. Bar</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>3/14/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHUNG K. BAR</u>				23D. ADDRESS <u>1213 LIGHT ST. (30)</u> <u>65/2777/1184</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>MARCH 17, 1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>GLENN HAVEN - GLENN AVENUE</u> <u>MD.</u>	
24D. LOCATION <u>A.A.</u> (City, town, or county) <u>Co.</u> (State) <u>Md.</u>		24E. FUNERAL DIRECTOR <u>CURTIS E. EVANS</u> ADDRESS <u>1400 S. CHARLES ST. 21230</u> <u>BALTIMORE, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Curtis E. Evans</u>	

CURTIS E. EVANS

Chas. F. Evans

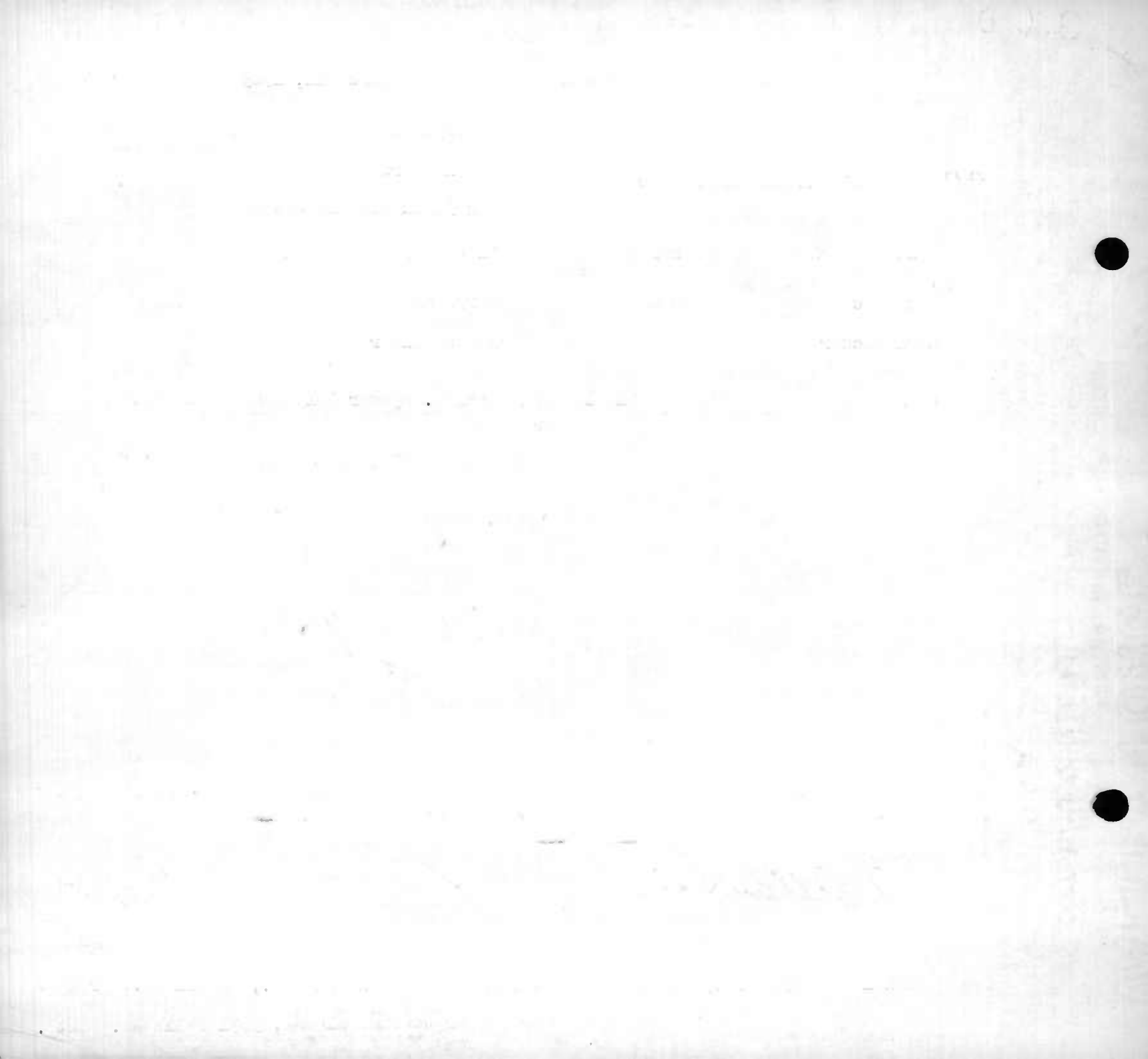
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Wm. Evans  
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2767</u>	
BIRTH NO. <u>65 2767</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>EDWARD ANDREW BECKER</u>		2. DATE AND HOUR OF DEATH <u>March 11, 1965</u> <u>11<sup>00</sup>A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>4430 Clydesdale Avenue</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-15</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4430 Clydesdale Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>21 Jan 1904</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Trucks</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Carl Becker</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Miller</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 10 6951</u>		17. INFORMANT <u>Carl R. Becker</u> ADDRESS <u>2815 Rona Road Balto 7 Md</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>392814-260X</u> <u>Cerebral thrombosis</u>		CAUSE OF DEATH (A) DUE TO <u>Generalized arteriosclerosis</u> (B) DUE TO <u>Diabetes mellitus</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>March 6, 1965</u> to <u>March 11, 1965</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>March 11, 1965</u> and that in ( <del>my</del> ) ( <del>an</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>A. Allan Sier</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3/13/65</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>15 Mar 65</u>		24C. NAME of CEMETERY or CREMATORY <u>Lake View Memorial Park</u>	
24D. LOCATION <u>Liberty Rd., Carroll Co., Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Burgen Funeral Home, 3631 Falls Rd. Balto. Md</u>	





BIRTH NO.

65 2768

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 2768

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ADA F. PEREGOY

2. DATE AND HOUR PRONOUNCED DEAD

March 13, 1965 10:05 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1217 W. 37th Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 1, 1900

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

James M. Baker

14. MOTHER'S MAIDEN NAME

Alice L. Gorsuch

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

ADDRESS

Marvin H. Peregoy, 1217 W. 37th St. Balto. Md.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/13/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

16 Mar 65

23C. NAME of CEMETERY or CREMATORY

Mt. Pleasant Cemetery

23D. LOCATION

(City, town, or county)

(State)

Gamber, Carroll Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Burgess Funeral Home, 3631 Falls Rd. Balto. Md

ADDRESS

WALLLEY FORD

Chas. 1st

BIRTH NO.

65 2769

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2769

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SARAH

HASTINGS

2. DATE AND HOUR PRONOUNCED DEAD

March 11, 1965

12:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

~~XXXXXX~~

Hanover

D. STREET ADDRESS (If rural, give location)

~~XXXXXX~~ Box 62-Dorsey Rd.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

June 12/85

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housekeeper

10B. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Rudolph Hoover

14. MOTHER'S MAIDEN NAME

(unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

Mrs. Belva Jeffrey (daughter) Same As #4

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/11/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

March 15/65

23C. NAME of CEMETERY or CREMATORY

King's Meth. Church Cem.

23D. LOCATION

(City, town, or county)

Laurel, Deleware

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Richard V. Singleton, Glen Burnie, Md.

VALLEY

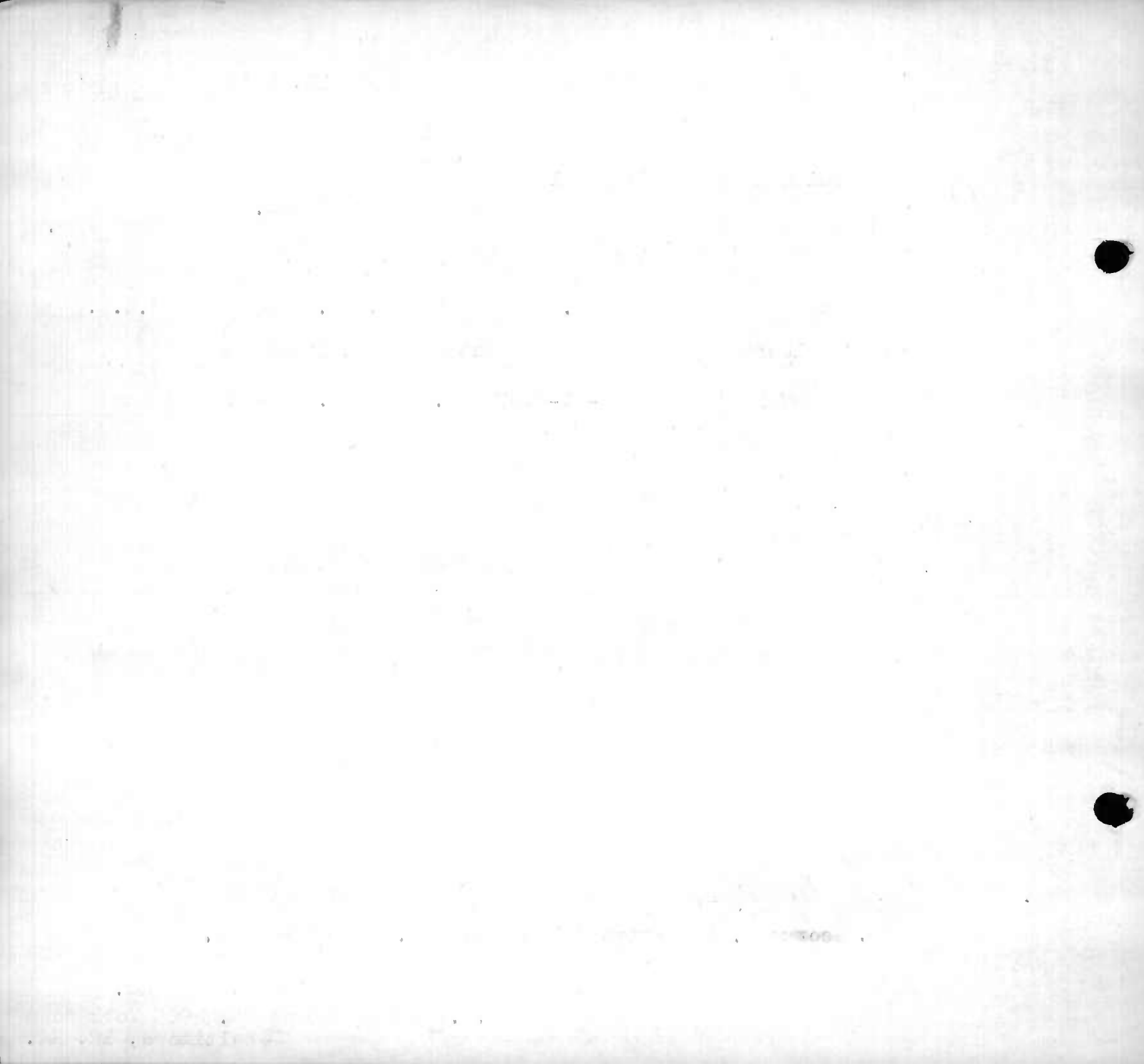
PHOTOGRAPH

Chambers

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2770				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2770	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Harry Fulton Colbert</b>				2. DATE AND HOUR OF DEATH <b>March 11, 1965</b> <b>11:30</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2927 Guilford Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>12/6/1892</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Canning Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Bernard Colbert</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Callahan</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>216-01-6167</b>		17. INFORMANT <b>Mrs. Cecile B. Colbert</b>		ADDRESS <b>(Same)</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b> <b>Suicidal Asphyxiation</b> <b>Myocarditis</b> <b>Arteriosclerosis</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>Immediate</b> <b>about 2 yrs</b> <b>Unknown</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 23rd 1965</b> to <b>March 3rd 1965</b> , that (I) (we) last saw the deceased alive on <b>March 3rd 1965</b> and that in (my) <b>four</b> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <b>(did not)</b> view the body after death.							
23A. SIGNATURE <b>Geo W Murgatroyd M.D.</b>				23B. DATE SIGNED <b>3/12/65</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. George W. Murgatroyd</b>				23D. ADDRESS <b>1261 E. Belvedere Ave.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/15/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Road Baltimore, 12, Md.</b>	



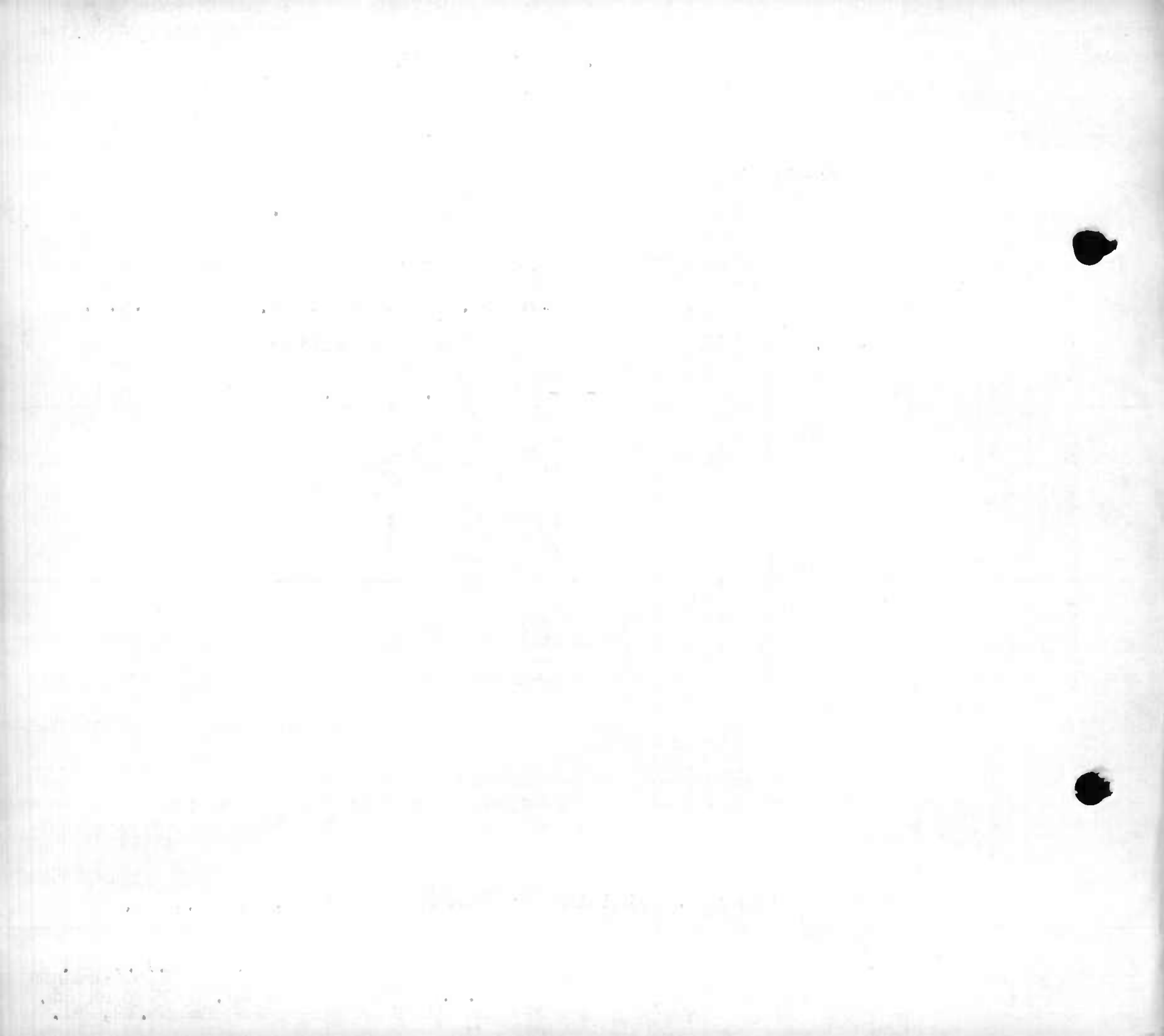


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 2771</b>	
BIRTH NO. <b>65 2771</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		<b>J. Graham Hartzell</b>		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Graham J. Hartzell</b>				<b>3-12-65 11:55 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hospital</b>		A. STATE <b>Maryland</b>		B. COUNTY <b>27-48</b>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>823 Evesham Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>12/5/1904</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Telephone Co. Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob G. Hartzell</b>		14. MOTHER'S MAIDEN NAME <b>Ella Mae Collier</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-0580</b>		17. INFORMANT <b>Mrs. Marie E. Hartzell</b>	
				ADDRESS <b>(Same)</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Papillary Carcinoma of Bladder</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>3-12-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>He</del> (this hospital) attended the deceased from <b>2-8-65</b> to <b>3-12-65</b> , that (I) (we) last saw the deceased alive on <b>3-12-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald A. Deinlein</b>				23B. DATE SIGNED <b>3-12-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Donal A. Deinlein</b>				23D. ADDRESS <b>Mercy Hospital, Balto., Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/16/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Parkville, Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>	

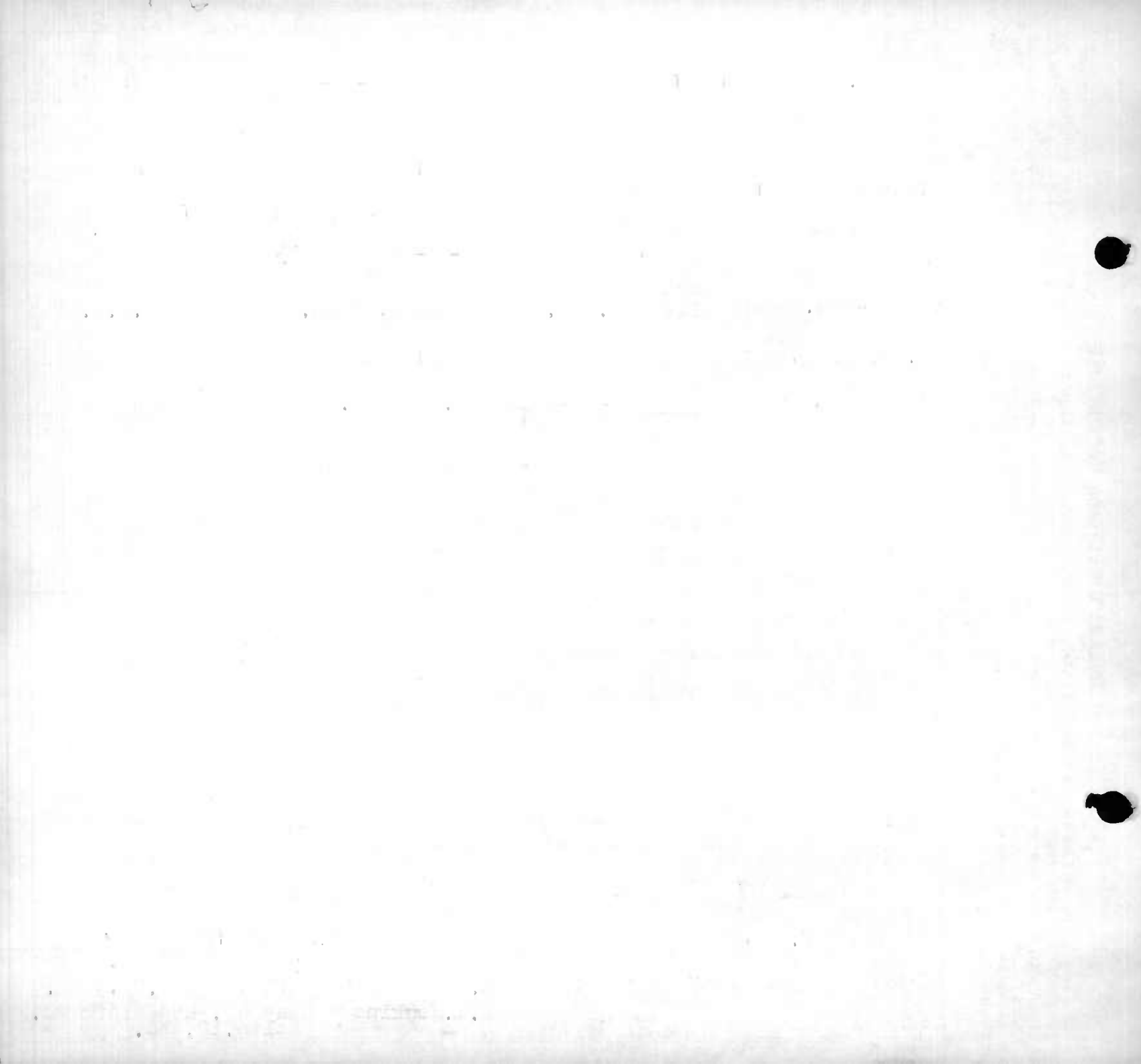




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

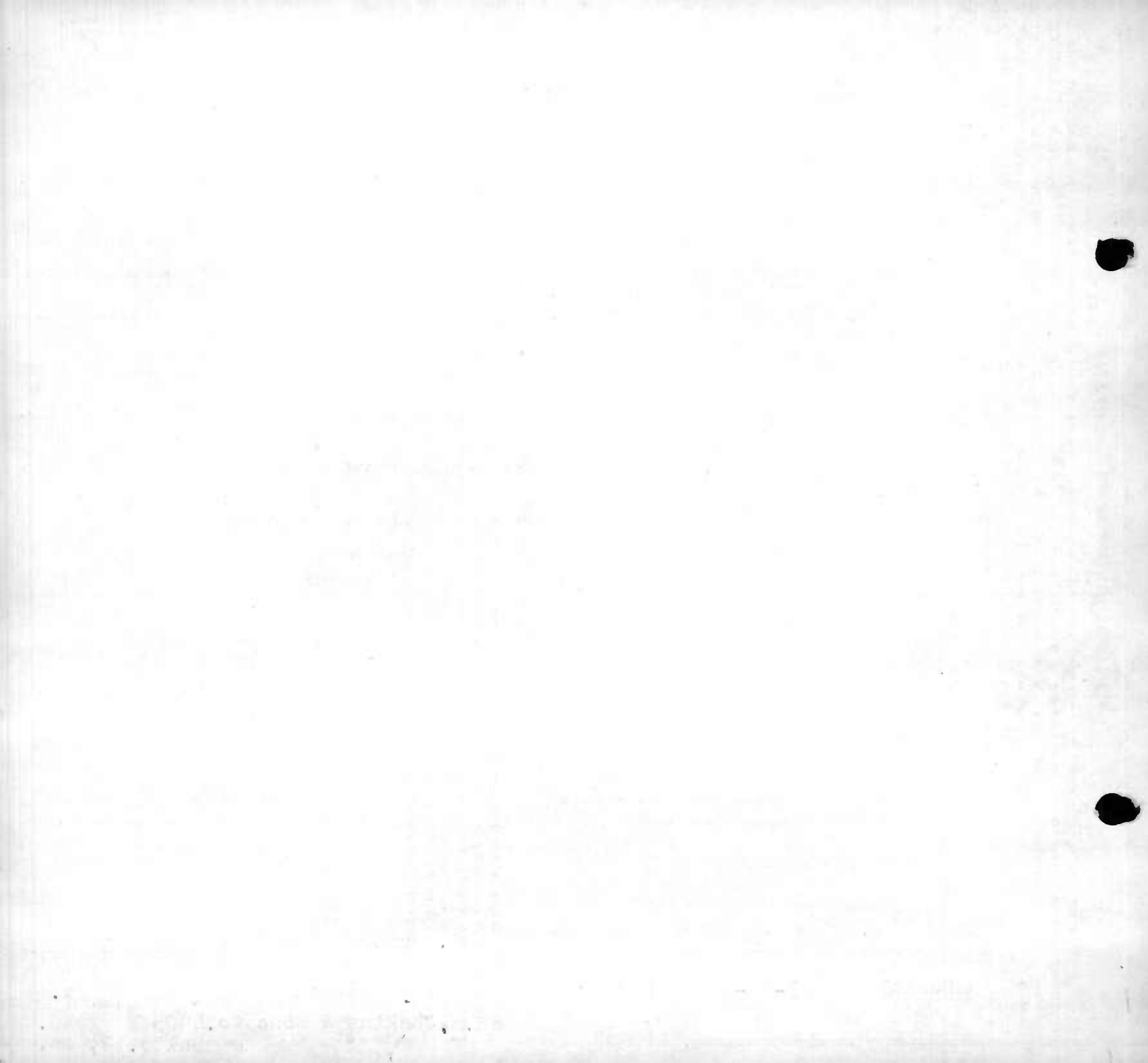
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH					Registered No. <u>65 2772</u>						
BIRTH NO. <u>65 2772</u>					M.E. CASE NO. <u>65 2772</u>						
1. NAME OF DECEASED (Type or Print) <u>R. RUSSELL SWIGERT</u>					2. DATE AND HOUR OF DEATH <u>3-14-65</u>   <u>6:40AM</u> M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>12-01</u>						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>						
					D. STREET ADDRESS (If rural, give location) <u>3908 NORTH CHARLES STREET</u>						
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>10-25-91</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Gen. Agent</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Life Ins. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Newville, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>J. CLYDE SWIGERT</u>					14. MOTHER'S MAIDEN NAME <u>ELIZABETH RUSSELL</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>					16. SOCIAL SECURITY NO. <u>220-30-5632</u>		17. INFORMANT <u>Mrs. Dagny H. Swigert</u> ADDRESS <u>(Same)</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES <u>Generalized arteriosclerosis</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) <u>Cerebral Thrombosis</u> DUE TO (B) <u>Generalized arteriosclerosis</u> DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>2-22-65</u> 19 to <u>3-14-65</u> 19 that (I) (we) last saw the deceased alive on <u>3-14-65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>James F. Fries</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3-14-65</u>				
23C. PHYSICIAN'S NAME (Type) <u>JAMES F. FRIES</u>					23D. ADDRESS M.D. <u>THE JOHNS HOPKINS HOSPITAL</u>						
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/16/1965</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cem.</u>			24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co., Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1965</u>		25B. NAME OF REGISTRAR <u>R. B. E. Jenkins</u>		25C. FUNERAL DIRECTOR'S ADDRESS <u>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</u>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2773</u>	
BIRTH NO. <u>65 2773</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>65 2773</u>		1. NAME OF DECEASED (Type or Print) <u>Koch, Mrs. Mary Price</u>		2. DATE AND HOUR OF DEATH <u>3/12/65</u> <u>8 25 PM</u>	
3. PLACE OF DEATH <u>IN BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>Roland View Towers #1011</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	B. DATE OF BIRTH <u>6/7/1885</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. WIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>GEORGE HARRY PRICE</u>		14. MOTHER'S MAIDEN NAME <u>AOA McCLEARY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-07-3029</u>		17. INFORMANT <u>Son : 207 Hawthorne Rd. #10</u>	
18. <u>422.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebellar hemorrhage</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic cardiovascular disease</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>3/12</u> 19 <u>65</u> to <u>3/12</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>8 25 PM</u> <u>3/12</u> 19 <u>65</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joe Hyman Sohn</u>				23B. DATE SIGNED <u>3/12</u>	
23C. PHYSICIAN'S NAME (Type) <u>Joe Hyman Sohn</u>		23D. ADDRESS <u>Md. General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-15-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Fairview</u>	
24D. LOCATION <u>Altoona</u>		24E. ADDRESS <u>Pa.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1965</u>		25B. NAME OF REGISTRAR <u>R. E. Stabey</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u>	
				25D. ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>	



J-525

65 2774

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2774

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ACNES A. JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

3/12/65

3:34 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2854 Rosalind Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2854 Rosalind Ave.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

3/25/1905

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Pvt. Family

11. BIRTHPLACE (State or foreign country)

Bowers Hill Va.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Henry Stephson

14. MOTHER'S MAIDEN NAME

? ? ? ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mildred T. Ashburn-2854 Rosalind Ave.

18. 443X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive cardiovascular disease  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

W.U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

3/12/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/16/1965

23C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Pk. Baltimore Co. Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

Herbert E. Nutter-3035 W. North Ave.

ADDRESS

VALLEY POLICE

AND CRIMINALS

THE



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2775		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2775	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
NAOMI MORRIS		3-14-65 12:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
LUTHERAN HOSPITAL OF MD.		MARYLAND BALTIMORE			
5. SEX		6. RACE			
F		C			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Married		5-2-09		55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Teacher		Public School		Baltimore Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George F. Holmes		Rebecca Gardner		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		214-40-5270		Charles P. Morris-6118 Old Frederick Road	
18. 420.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) ACUTE MYOCARDIAL INFARCTION			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(B) RHEUMATIC HEART DISEASE			
ANTECEDENT CAUSES		(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		CONGESTIVE HEART FAILURE			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3-14 1965 to 3-14 1965, that (I) (we) last saw the deceased alive on 3-14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Renato A. Espina				3/14/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
RENATO A. ESPINA				LUTHERAN HOSP. OF MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/18/65		Arbutus Memorial Pk.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 15 1965		Robert E. Taylor		Herbert E. Nutter-3035 W. North Ave	

WESTERN HOSPITAL OF MD

WILLIAM S. THOMPSON

2-5-60

ACUTE MYOCARDIAL  
INFARCTION  
ISCHEMIC HEART DISEASE

CONGESTIVE HEART FAILURE

WESTERN HOSPITAL OF MD

REMARKS: A. ESTIMATED

LESS A. ESTIMATED

OO

2-10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

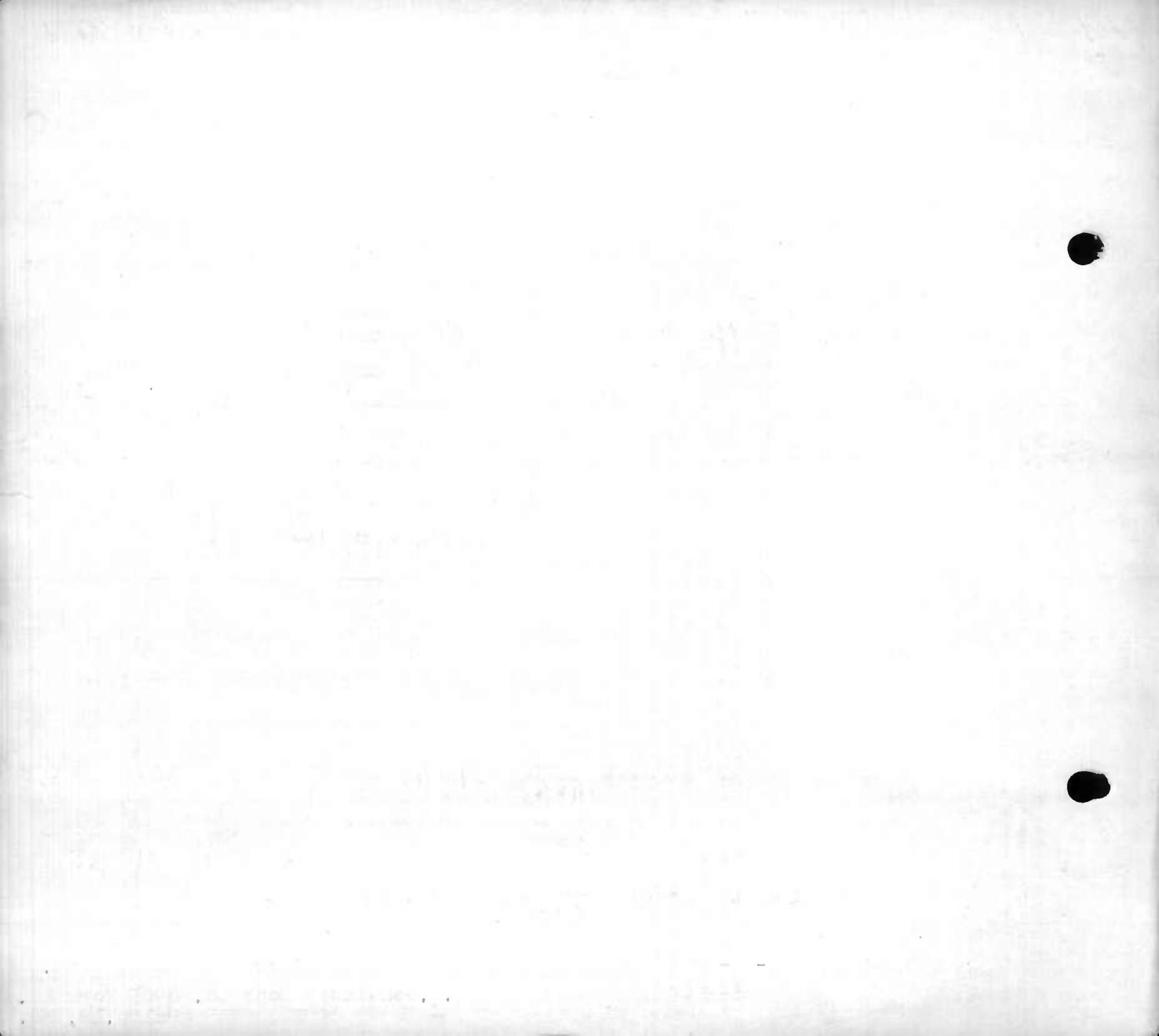
BIRTH NO. 65 2776				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2776	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) OTTILIE Elizabeth Smith				2. DATE AND HOUR OF DEATH MARCH 14, 1965 8 30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION Memorial Hospital BALTIMORE, Maryland		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 12-01	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 615 Broadview Apts.			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 4/11/1874	9. AGE (In years lost birthday) 90	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HENRY Smith				14. MOTHER'S MAIDEN NAME ELIZA DIETZ			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 1		17. INFORMANT MRS. CORDELIA SWARTZ 5111 BROOK GREEN RD.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) PNEUMONIA complicating FRACTURED Left Hip also ARTERIOSCLEROSIS				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NONE		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 615 Broadview Apts			
21D. TIME OF INJURY (APPROX.) 3 8 65 100 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell on way to bathroom			
22. I certify that (I) (this hospital) attended the deceased from March 8 19 65 to March 14 19 65, that (I) (we) last saw the deceased alive on March 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE David M. Mac Millan				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED MARCH 14, 1965	
23C. PHYSICIAN'S NAME (Type) DAVID M. MAC MILLAN				23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/17/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1965		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2777	
BIRTH NO. 65 2777		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOSEPH J. NOPPENBERGER		2. DATE AND HOUR OF DEATH 3-12-65 11 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL		A. STATE Md. B. COUNTY BALTIMORE 27-10			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 4414, Old YORK ROAD. BALTO. 12			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1.16.1886	9. AGE (In years last birthday) 79	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINT. SUPT.		10B. KIND OF BUSINESS OR INDUSTRY STATE GOVT.		11. BIRTHPLACE (State or foreign country) BALTIMORE	
13. FATHER'S NAME George Noppenberger		14. MOTHER'S MAIDEN NAME Elizabeth T. Maguire		12. CITIZEN OF WHAT COUNTRY? USA.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-36-2422		17. INFORMANT Mrs. MARIE E. NOPPENBERGER ABOVE ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Recurrent Ca. Symptomatic Colon.		INTERVAL BETWEEN ONSET AND DEATH ? 4-6 months.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Metastases to Lung, (B) DUE TO Metastases to Liver. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/10/65 19 to 3/12/ 19 65, that (I) (we) last saw the deceased alive on 2/12/65 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.				23B. DATE SIGNED 2/12/65	
23C. PHYSICIAN'S NAME (Type) M. ZAFRULLAH KHAN M.D.		23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-15-65		24C. NAME of CEMETERY or CREMATORY New Cathedral	
				24D. LOCATION Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1965		25B. NAME OF REGISTRAR Robert E. Jenkins M.D.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

CLARENCE HELLMANDOLLAR, Jr

2. DATE AND HOUR PRONOUNCED DEAD

March 10, 1965

10:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21218

D. STREET ADDRESS (If rural, give location)

1825 North Charles Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

AUG. 15, 1931

9. AGE (In years  
lost birthday)

33

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Window washer

10B. KIND OF BUSINESS OR INDUSTRY

Self employed

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Clarence C. Hellmandollar, Sr

14. MOTHER'S MAIDEN NAME

Velvia Dickens

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Vernon Schilling, 833 W. 36th St., 21211

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Fracture of Cervical Spine with  
Compression of Cord.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

1800 N. Charles Street

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
3 10 '65 A.M.

21E. INJURY OCCURRED

WHILE AT WORK ☒NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Fell off ladder while washing  
windows.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/10/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

3-13-65

23C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Wm. Cook, Inc., 1217 St. Paul Street, 21202

ADDRESS



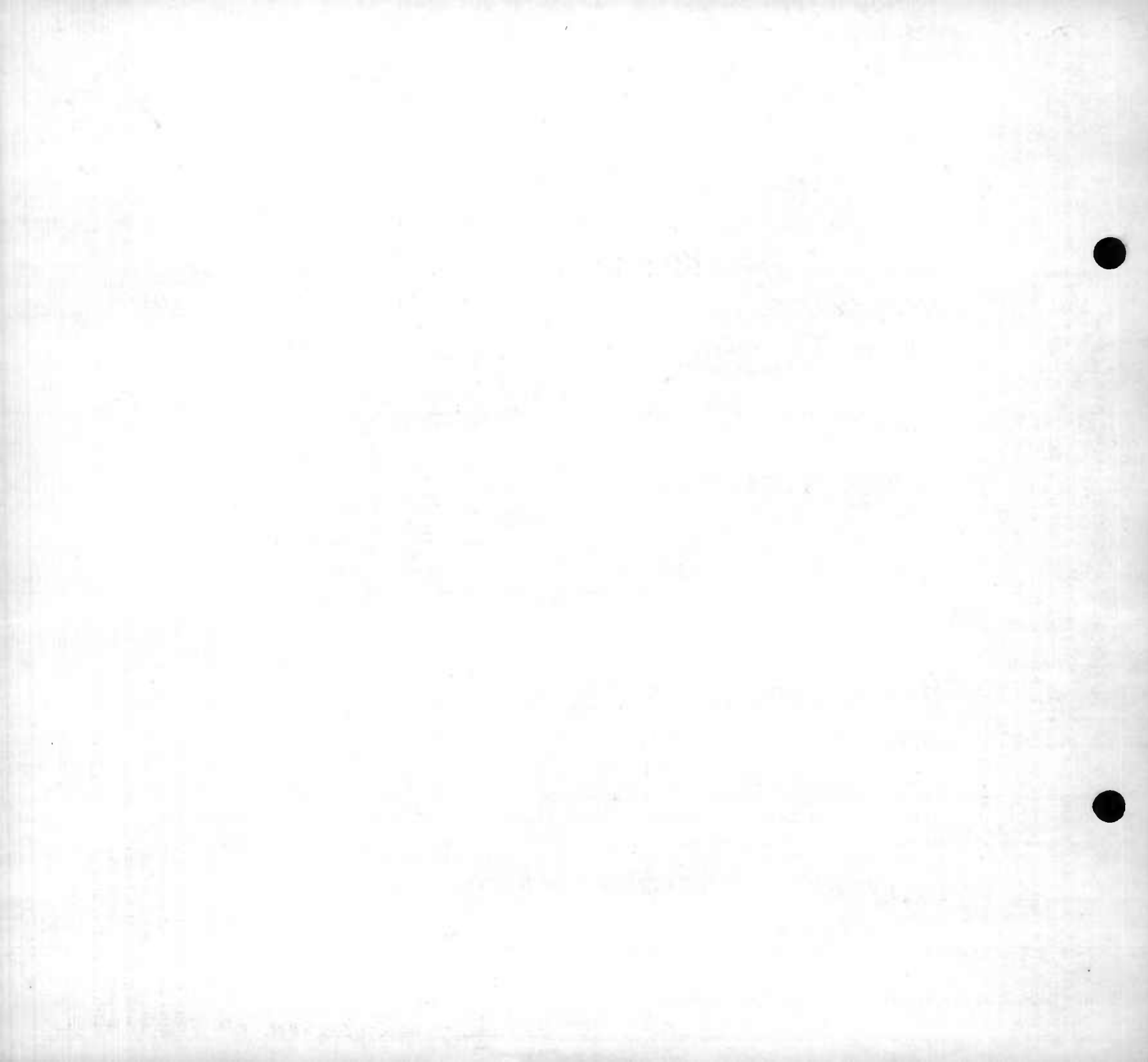
WALLEY HOUSE

Chas. H. Walley

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

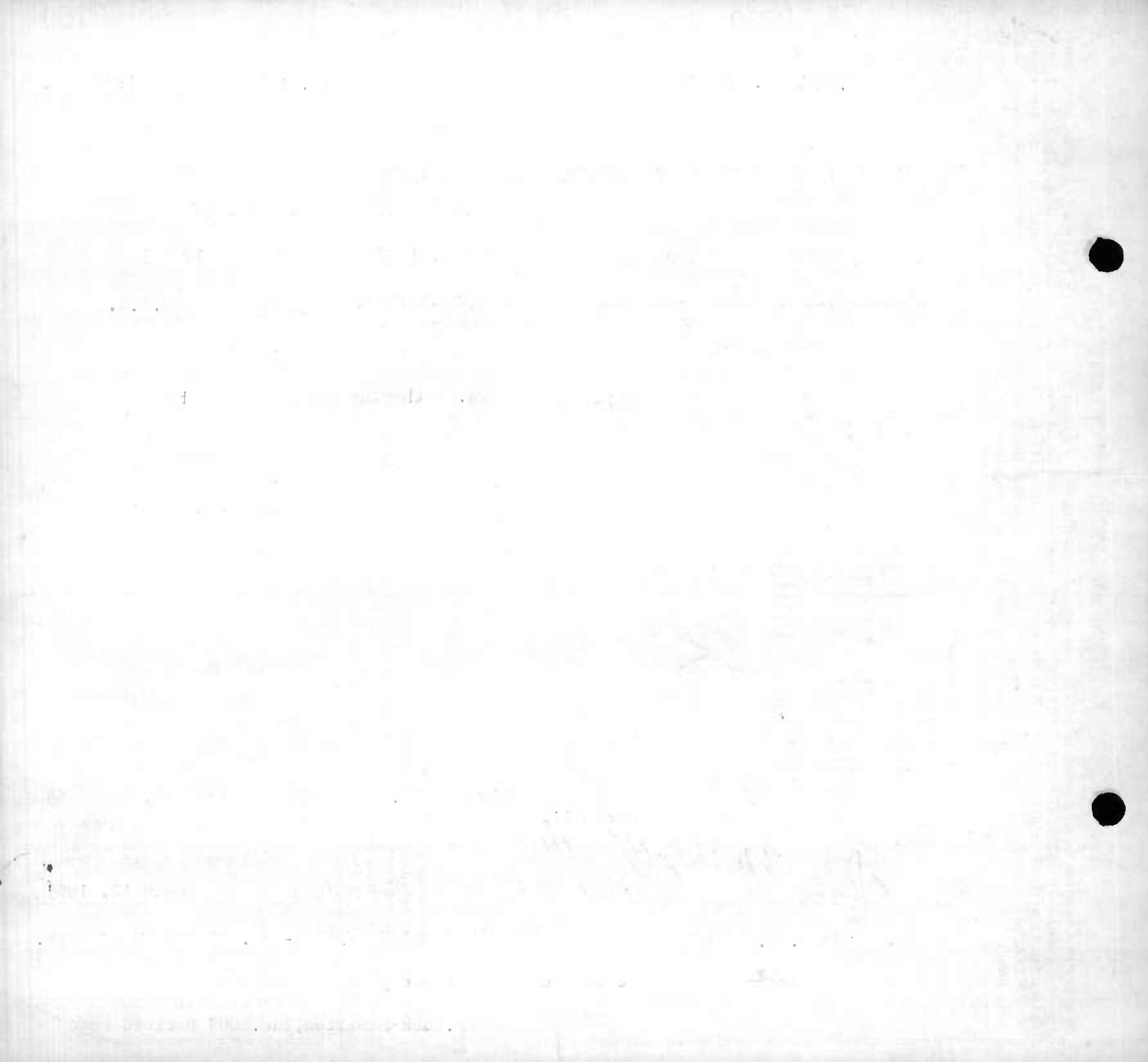
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 2779</span>	
BIRTH NO. <span style="float: right;">104-720</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>GRACE W. COOK</b>		2. DATE AND HOUR OF DEATH <b>3-10-65 5:20 PM</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1633 NORTHERN P-TWAY</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>WOMEN'S HOSPITAL BALT MD.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALT MD</b>			
		D. STREET ADDRESS (If rural, give location) <b>27-38</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>4-2-1873</b>	9. AGE (In years last birthday) <b>91</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTO, MD USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WILLIAM T FIELDS</b>		14. MOTHER'S MAIDEN NAME <b>GEORGIEANNA BARNES</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-52-0910</b>		17. INFORMANT <b>CHART &amp; SON</b>	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. If means the disease, injury or complication which caused death.) <b>Pulmonary edema 20</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) <b>Hypertensive arteriosclerosis</b> DUE TO <b>Heart Disease</b>			
(B)		(C)			
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-5</b> 19 <b>65</b> to <b>3-10</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3-10</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Angela A. Tjandra</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>ANGELITA TOPPAS</b>		23D. ADDRESS <b>WOMEN'S HOSP. BALD. 17 MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>MARCH 13/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>GREENMOUNT</b>	
24D. LOCATION (City, town, or county) (State) <b>NORTH AVE - BALTIMORE, MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>			
25B. NAME OF REGISTRAR <b>Paul E. Tjandra</b>		25C. FUNERAL DIRECTOR <b>W. M. Cook</b>			
25D. ADDRESS <b>TOWSON, INC, TOWSON, MD.</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 2780	
BIRTH NO.				65 2780	
M.E. CASE NO.				Registered No.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
RONALD W. HARRIS			MARCH 12, 1965		1:00 A. M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
MARYLAND STATE PENITENTIARY HOSPITAL 954 FORREST STREET			MARYLAND BALTIMORE		
5. SEX			6. RACE		
MALE			WHITE		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH		
SEPARATED			MAY 9, 1905		
9. AGE (In years lost birthday)			10. Under 1 Yr. Months Days		
59			10 3		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
CHESTERTOWN, MARYLAND			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOHN HARRIS			MARY FOX		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
NO			217-18-5563		
17. INFORMANT			ADDRESS		
Mrs. Catherine Harris, 3404 White Avenue					
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) COR PULMONALE		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			DUE TO		
ANTECEDENT CAUSES			(B) CHRONIC PULMONARY INSUFFICIENCY		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO		
II			(C) CAPILLARY ALVEOLAR BLOCK		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
NONE					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 15, 19 65 to March 12, 19 65, that (I) (we) last saw the deceased alive on March 11, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not) (did) (not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Henry W. D. Holljes</i>				MARCH 12, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DR. HENRY W. D. HOLLJES,				954 FORREST STREET - MD. PENITENTIARY HOSP.	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		3-12-65		Moreland Memorial Cemetery	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Baltimore		MAR 15 1965		Robert E. Taylor, M.D.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
				Wm. Cook-Hamilton, Inc. 6009 Harford Road	



BIRTH NO. 65 2781 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2781

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARTHA HAWKINS

2. DATE AND HOUR PRONOUNCED DEAD

3/11/65 1:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

810 W. Lexington St. Apt. 10

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Sept. 17, 1901

9. AGE (In years  
last birthday)

63

10. If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Murray

14. MOTHER'S MAIDEN NAME

Rachel Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Lewis Hawkins 810 W. Lexington St. Apt. 10

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)Arteriosclerotic and hypertensive cardio-  
vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.A. P. BERNHARDT  
Superintendent

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

W.U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

3/12/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

March 15, 1965

23C. NAME OF CEMETERY or CREMATORY

Balto. National Cem.

23D. LOCATION

(City, town, or county)

(State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Schowden St.

ADDRESS

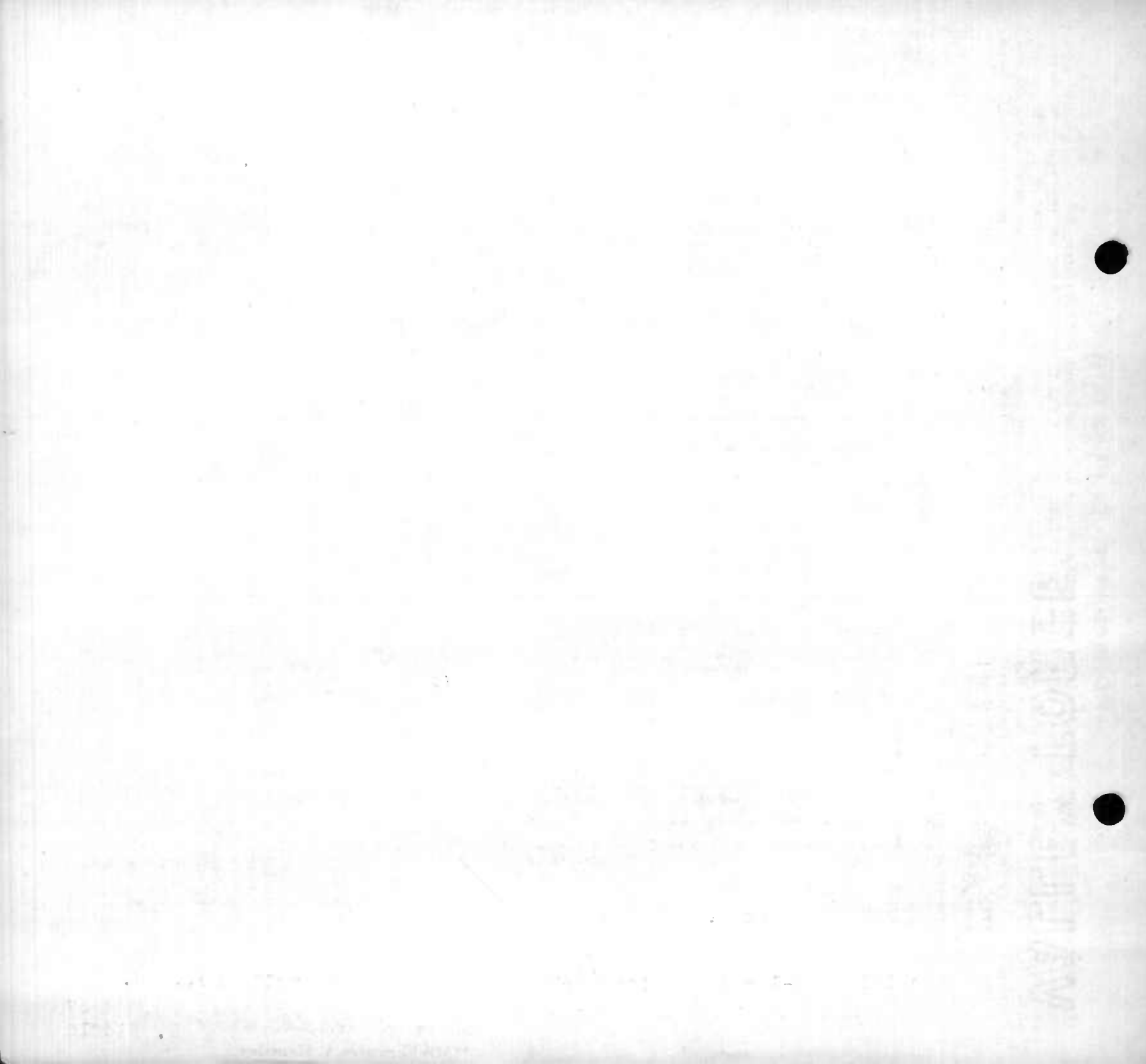




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 2782	
BIRTH NO. 65 2782		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LEWIS RAYMOND T		2. DATE AND HOUR OF DEATH 3/10/65 4:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street, address or location) UNIV HOSP BALTO MD.				A. STATE MD B. COUNTY BALTIMORE			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) 5300			
				D. STREET ADDRESS (If rural, give location) 4 A MILBERT CT			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3-8-03	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME THOMAS				14. MOTHER'S MAIDEN NAME MARY S. RHUBOTTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. ?		17. INFORMANT CHART		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) DUE TO PULMONARY CORNIC Lung Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO CHRONIC LUNG DISEASE			
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. C.V.A.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 1/26 1965 to 3/10 1965, that (I) (we) lost saw the deceased alive on 3/10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE D. A. Culotta M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stiff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/10/65	
23C. PHYSICIAN'S NAME (Type) Dominic A. Culotta D.A. CULOTTA M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-14-65		24C. NAME OF CEMETERY OR CREMATORY White Rock		24D. LOCATION (City, town, or county) (State) Carroll Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR (Mrs) Frances A. Hemmley		ADDRESS 578 W. Biddle St	



## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

65 2783

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2783

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GEORGE

FISHER

2. DATE AND HOUR PRONOUNCED DEAD

March 11, 1965

12:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

663 W. Franklin Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Divorced

8. DATE OF BIRTH

June 29, 1892

9. AGE (in years  
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

George Fisher

14. MOTHER'S MAIDEN NAME

Rosa Burton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs Sarah Fisher

ADDRESS 1399

Argyle Av.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease

XXXXXX

with Asymmetrical Hypertrophy of  
Interventricular Septum.XXXX  
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/11/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3-16-65

23C. NAME of CEMETERY or CREMATORY

National Cem

23D. LOCATION

(City, town, or county)

Baltimore,

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

578 W. Ridge St.

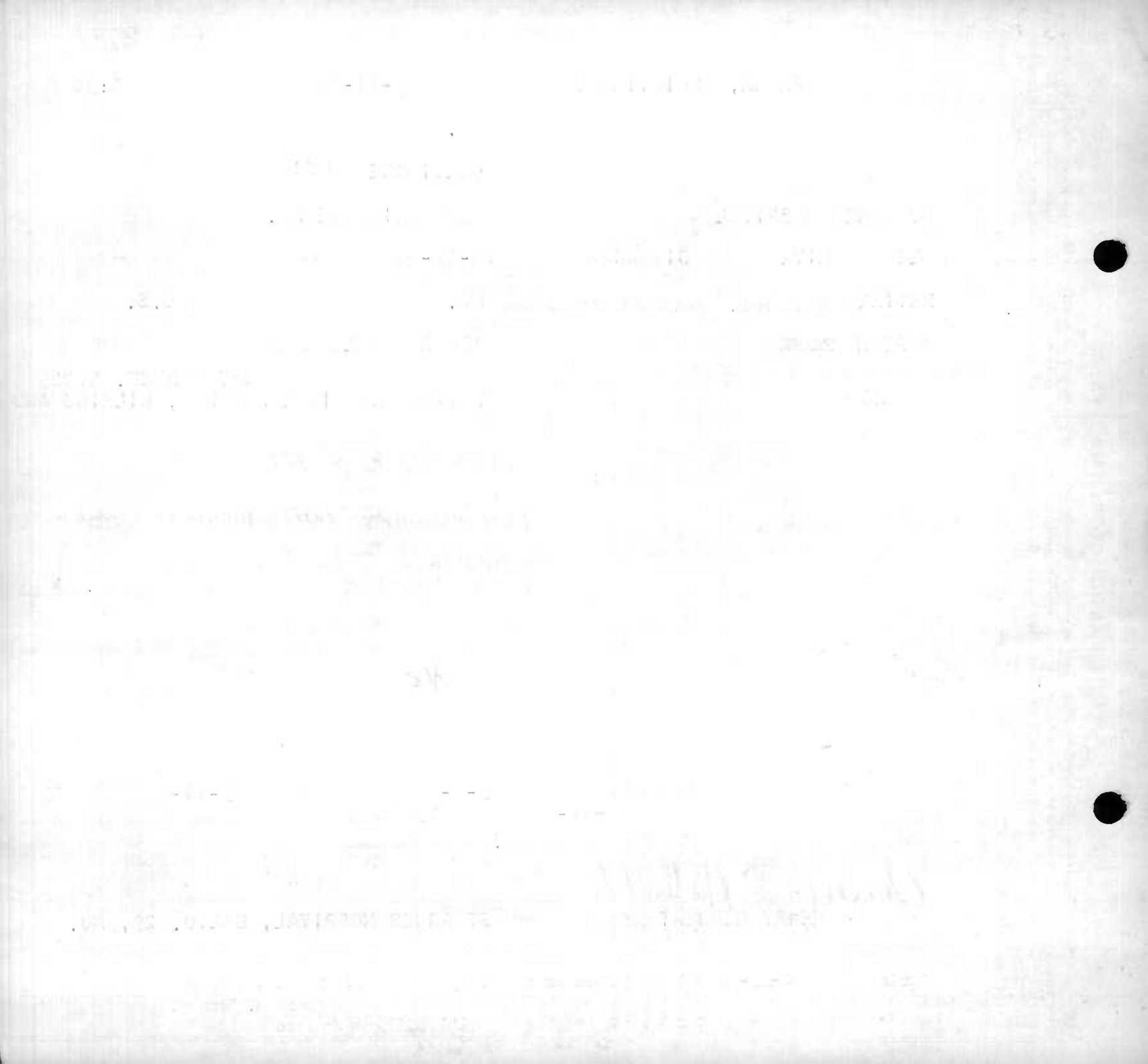
WALLINGTON POLICE

John P. [unclear]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2784		REGISTERED NO. 65 2784	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				FRANK, CHRISTIAN J		3-11-65 2:30 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE MD.		B. COUNTY 25-31	
ST AGNES HOSPITAL				C. CITY OR TOWN BALTIMORE 21229		D. STREET ADDRESS 558 BRISBANE RD.	
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED		8. DATE OF BIRTH 10-27-96	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Office Mgr.		10B. KIND OF BUSINESS OR INDUSTRY National Carloading		9. AGE (In years last birthday) 68		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME JOSEPH FRANK				14. MOTHER'S MAIDEN NAME BARBARA SCHLAGENHAFT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT CATON AVES. 21229 ST AGNES HOSPITAL RECORDS, WILKINS AND	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				(A) DUE TO ASCVD & CHF		(B) DUE TO PULMONARY INFARCTION & SHOCK	
(C) TAILORING & SEVERE IRREVERSIBLE METABOLIC ACIDOSIS 50% ABOVE				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 0	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 3-2-19 65 to 3-11-19 65, that (I) (we) last saw the deceased alive on 3-11-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Henry R. Hubbard		23B. DATE SIGNED 3-11-65	
23C. PHYSICIAN'S NAME (Type) HENRY HERBERT		23D. ADDRESS ST AGNES HOSPITAL, BALTO. 29, MD.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-15-65	
24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 15 1965		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR'S ADDRESS Howard H. Hubbard 4107 Wilkens Avenue		25D. FUNERAL DIRECTOR'S ADDRESS		25E. FUNERAL DIRECTOR'S ADDRESS		25F. FUNERAL DIRECTOR'S ADDRESS	



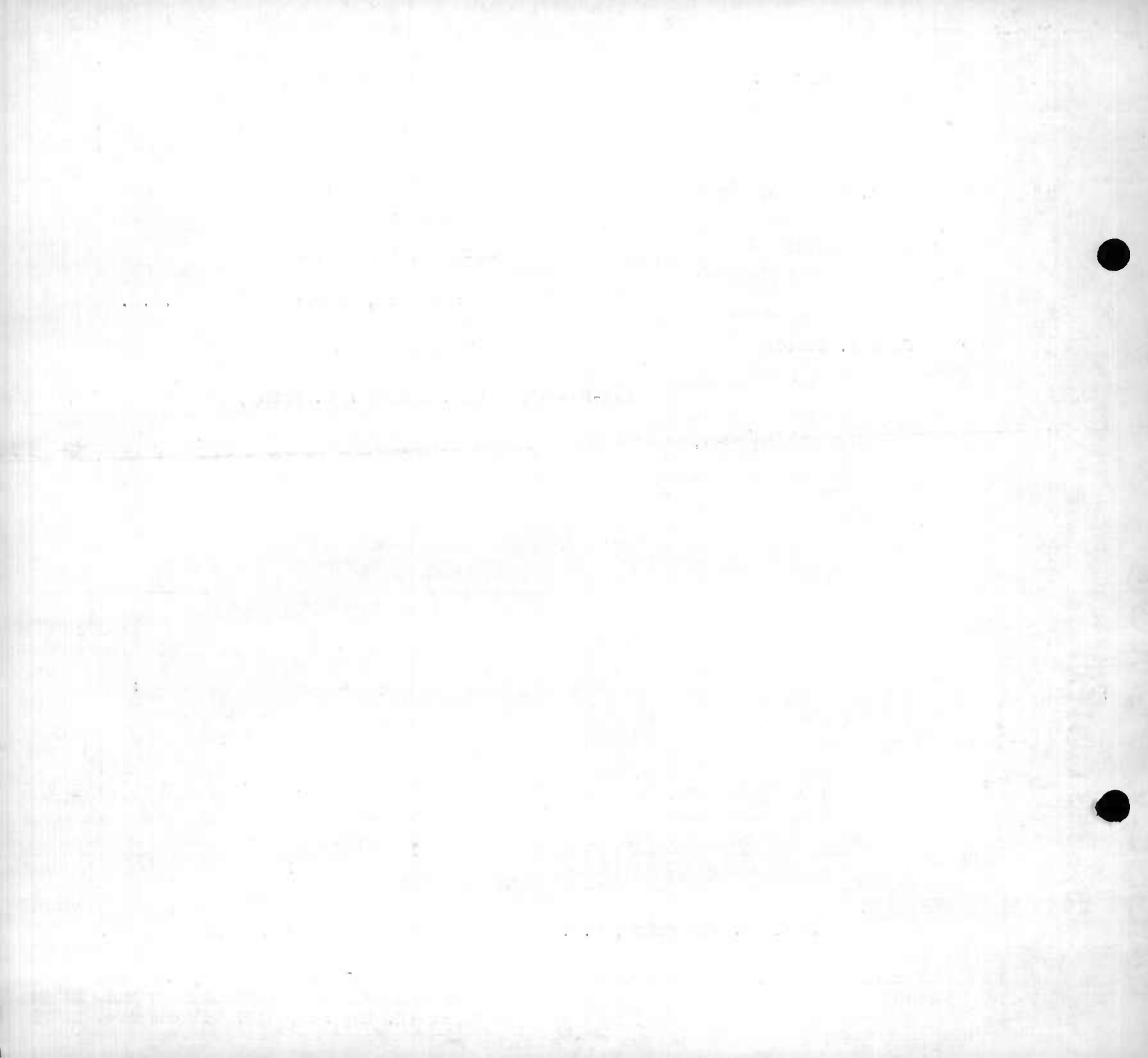


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH						Registered No. <span style="font-size: 1.2em;">65 2785</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 2785</span>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Marie B. Bezold</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">March 10, 1965</span>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.1em;">St. Agnes Hospital</span>		(If not in hospital or institution, give street address or location)		A. STATE <span style="font-size: 1.1em;">Maryland</span>		B. COUNTY <span style="font-size: 1.2em;">25-41</span>	
5. SEX <span style="font-size: 1.1em;">Female</span>		6. RACE <span style="font-size: 1.1em;">White</span>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.1em;">Single</span>		8. DATE OF BIRTH <span style="font-size: 1.1em;">April 3, 1893</span>	
9. AGE (In years last birthday) <span style="font-size: 1.1em;">71</span>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Baltimore, Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">U.S.A.</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <span style="font-size: 1.1em;">John A. Bezold</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Theresa Peters</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">212-03-0125</span>		17. INFORMANT ADDRESS <span style="font-size: 1.1em;">Mrs. Isabella H. Darby, 904 Calwell Rd. 21229</span>			
18. <span style="font-size: 1.2em;">420.1 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <span style="font-size: 1.1em;">myocardial infarction</span>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <span style="font-size: 1.2em;">myocardial infarction</span> DUE TO (B) DUE TO (C)  <span style="font-size: 1.2em;">Interval - Sudden</span>		INTERVAL BETWEEN ONSET AND DEATH  <span style="font-size: 1.2em;">Sudden</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<span style="font-size: 1.2em;">Anterior - Sclerotic C-V. Disease - Previous Coronary</span>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">11/18</span> 19 <span style="font-size: 1.1em;">60</span> a <span style="font-size: 1.1em;">3/10</span> 19 <span style="font-size: 1.1em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">3/10</span> 19 <span style="font-size: 1.1em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">James N. Frederick</span>				M.D. <input type="checkbox"/> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.1em;">3/11/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">James N. Frederick, M.D.</span>				23D. ADDRESS <span style="font-size: 1.1em;">1311 Francis Avenue, Baltimore, Md. 21227</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">3/15/1965</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.1em;">Lakeview Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Carroll County, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 15 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.1em;">Howard H. Hubbard</span>		ADDRESS <span style="font-size: 1.1em;">4107 Wilkens Ave. 21229</span>	

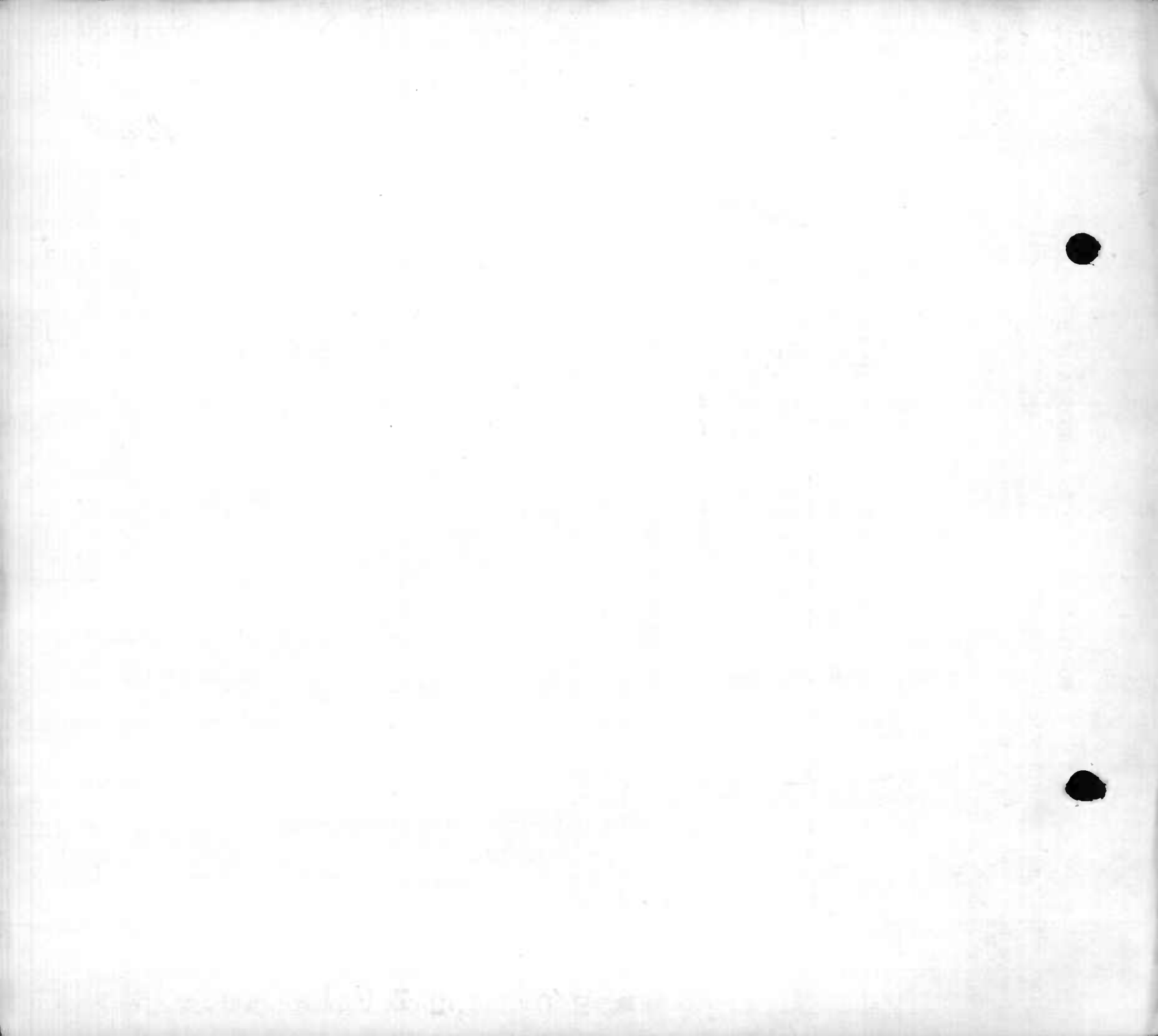




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2786	
BIRTH NO. 65-652786		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Baby Girl Shriver</i>		2. DATE AND HOUR OF DEATH <i>3-12-65 5 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>7337 Conley St.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Gordon Shriver</i>			14. MOTHER'S MAIDEN NAME <i>Florence Mochivent</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Gordon Shriver 7337 Conley St</i>	
18. <i>776 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Prematurity</i> DUE TO  (B) DUE TO  (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>3 1/4 hours</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 11 1965</i> to <i>March 12 1965</i> , that (I) (we) last saw the deceased alive on <i>March 12</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Melba B. Salanio</i>				23B. DATE SIGNED <i>3-12-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>MELBA B. SALANIO</i>		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3-13-65</i>	24C. NAME OF CEMETERY or CREMATORY <i>Holy Rosary</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Co. M.D.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Monk Fielkowski 2007 Eastern Ave.</i>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2787</u>	
BIRTH NO. <u>65 2787</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>SAMUEL E. JOHANCEN</u>		2. DATE AND HOUR OF DEATH <u>March 10, 1965</u>   <u>2:20</u> a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>3442 Chestnut Avenue</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>13-06</u>			
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	
8. DATE OF BIRTH <u>Nov. 9, 1893</u>		9. AGE (In years last birthday) <u>71</u>		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Samuel Johancen</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Gentner</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>213 09 9592</u>	
17. INFORMANT <u>Ruth J. Miller, 158 Laverne Avenue</u>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 1955</u> to <u>3-10 1965</u> , that (I) (we) last saw the deceased alive on <u>3-8 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Reuben Hoffman</u>				23B. DATE SIGNED <u>3-11-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>REUBEN HOFFMAN</u>				23D. ADDRESS <u>846 W. 36th St</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>March 12, 1965</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION <u>Pikesville, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>Bugge Funeral Home</u>		25D. ADDRESS <u>3631 Falls Rd Balto. Md.</u>		25E. SIGNATURE <u>Reuben Hoffman</u>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2788				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2788	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>AGNES M. HERSCHEL</b>				2. DATE AND HOUR OF DEATH <b>MARCH 11, 1965 7:00 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>357 YALE AVE.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>20-08</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>357 YALE AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>NOV 13, 1876</b>	9. AGE (In years last birthday) <b>88</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>PATRICK HICKEY</b>				14. MOTHER'S MAIDEN NAME <b>SARAH NICEFOX</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>_____</b>		17. INFORMANT <b>Leo Herschel - 357 Yale Ave.</b>		ADDRESS	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>arteriosclerotic Cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>March 31, 1960</b> to <b>March 11, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 11, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Harry L. Knipp</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3-12-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>HARRY L. KNIPP</b>				23D. ADDRESS <b>4116 Edmondson Ave #29</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-15-65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cathedral Em.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>		25C. FUNERAL DIRECTOR <b>John J. Talbot</b>		ADDRESS <b>Home Baltimore, Md.</b>	





BIRTH NO. 65 2789 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2789

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

PEARL WALTERMEYER

2. DATE AND HOUR PRONOUNCED DEAD

11 March 1965

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

3117 Sumter Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3117 Sumter Ave.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

JAN-7-1925

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

✓

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Leonard STAUBLY

14. MOTHER'S MAIDEN NAME

POWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

✓

16. SOCIAL  
SECURITY NO.

✓

17. INFORMANT

Elson Wattermeyer 3117 Sumter Ave.

ADDRESS

18. 032X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cardiac tamponade  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) rupture of aneurysm of aorta  
DUE TO

(C).....

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes-partial

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/11/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Mar-15-65

23C. NAME of CEMETERY or CREMATORY

Lorraine Park

23D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

24B. NAME OF REGISTRAR

Charles S. Petty

24C. FUNERAL DIRECTOR

Septimo Perry 5040 Connelley

ADDRESS

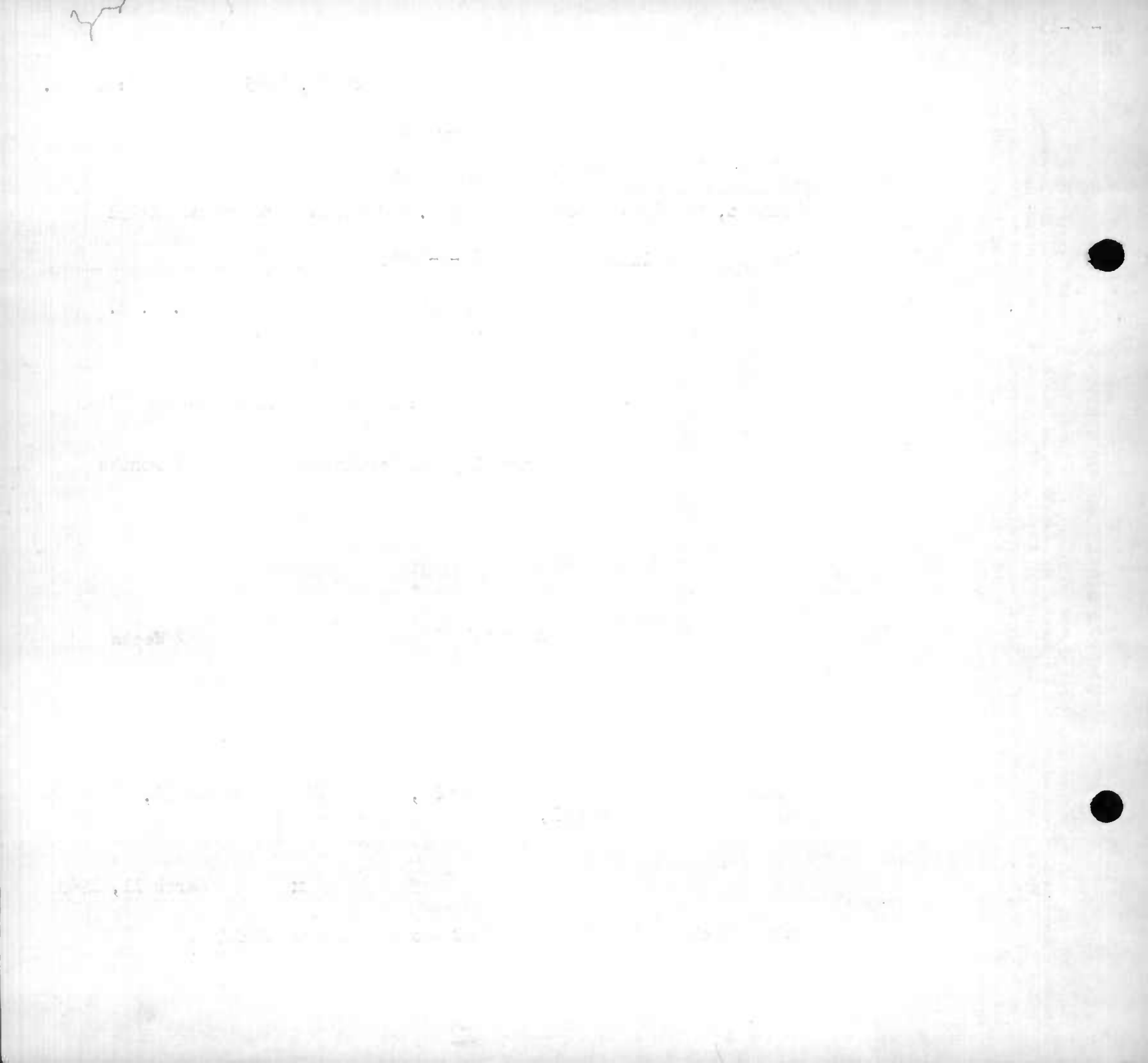
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41-90-15  
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 2790	
BIRTH NO. 65 2790				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>Louis Evers</b>				2. DATE AND HOUR OF DEATH <b>March 11, 1965 12:55 A. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>6-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>203 N. Patterson Park Avenue 21231</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>12-9-1898</b>	9. AGE (In years last birthday) <b>66 67</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ornamental iron worker</b>			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Willaim Evers</b>			14. MOTHER'S MAIDEN NAME <b>Jennie ?</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 1</b>			16. SOCIAL SECURITY NO. <b>214-01-5271</b>		17. INFORMANT ADDRESS <b>RECORDS: BCH 4940 Eastern Avenue 21224</b>		
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Bronchiogenic Carcinoma</b> DUE TO (B) _____ DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH <b>7 Months</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Pneumonia</b>				<b>2 Weeks</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>October 19, 1964</b> to <b>March 11, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 11, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Robert Cooke</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>March 11, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert Cooke</b>				23D. ADDRESS <b>4940 Eastern Avenue 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/15/64</b>	24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 15 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Ulrich Funeral Home 4210 Belair Road</b>			



BIRTH NO.

M.E. CASE NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

ELIJAH

SIMMS

2. DATE AND HOUR PRONOUNCED DEAD

March 10, 1965

4:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)War Memorial Plaza  
Lexington Street4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2525 W. Belvedere Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Jan. 2, 1892

9. AGE (In years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Insurance broker

10B. KIND OF BUSINESS OR INDUSTRY

Insurance

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Simms

14. MOTHER'S MAIDEN NAME

Caroline Bishop

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

John T. Simms 8309 Dalesford Road 21234

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Shotgun Wound of Head.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Plaza

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Lexington Street

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
3 10 '65 P

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head.

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/11/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/13/65

23C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county)

Parkville, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 15 1965

24B. NAME OF REGISTRAR

Robert E. Foy

24C. FUNERAL DIRECTOR

Ullrich Funeral Home 4210 Belair road.

ADDRESS

Glenn, J. P.



BIRTH NO. 65 2792		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2792	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
		MARJORIE E. HOLT		March 10, 1965 6:00 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)			
FULL NAME OF DECEASED (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
2229 Cloville Avenue		Maryland			
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
		Baltimore 27-06			
		D. STREET ADDRESS (If rural, give location)			
		2229 Cloville Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Female	White	Married	Mar. 31, 1910	55 54	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		Altoona Blair Co. Pa.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Frank Sisker		Sarah Berice Schultzeberger		U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Agnes E. Holt 2229 Cloville Ave Balto 14, Md.	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Arteriosclerotic Cardiovascular Disease.			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		Yes	Yes		
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D.		DATE SIGNED	
Charles S. Petty, M.D.				3/11/65	
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY OR CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial	Mar. 13, 1965	Altoona		Altoona Blair Co. Pa.	
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS			
MAR 15 1965	Robert E. Taylor, M.D.	Charles E. Holt 2229 Cloville Ave Balto 14, Md.			





1  
G. 235

65 2793

BALTIMORE CITY HEALTH DEPARTMENT

65 2793

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ARCHIE GIUSTINA

2. DATE AND HOUR PRONOUNCED DEAD

March 13, 1965 5:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

**CERTIFICATE CORRECTED**  
5-4-65

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

222 S. Conklin Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

2-27-1927

9. AGE (In years  
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Knife Sharpener

10B. KIND OF BUSINESS OR INDUSTRY

Self employed

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Giustina

14. MOTHER'S MAIDEN NAME

Mary Mosca

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes WWII Army

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Lucy Pickering

ADDRESS

18. E983X1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Multiple Traumatic Injuries.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

House

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

2307 N. Charles Street

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)  
3 13 '65 A

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Jumped from 3d floor window of burning house.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED  
3/13/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/17/65

23C. NAME OF CEMETERY or CREMATORY

Holy Redeemer

23D. LOCATION

(City, town, or county)

(State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 16 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Joseph J. Zuccato, Jr. 263 S. Conklin St.

ADDRESS

2793

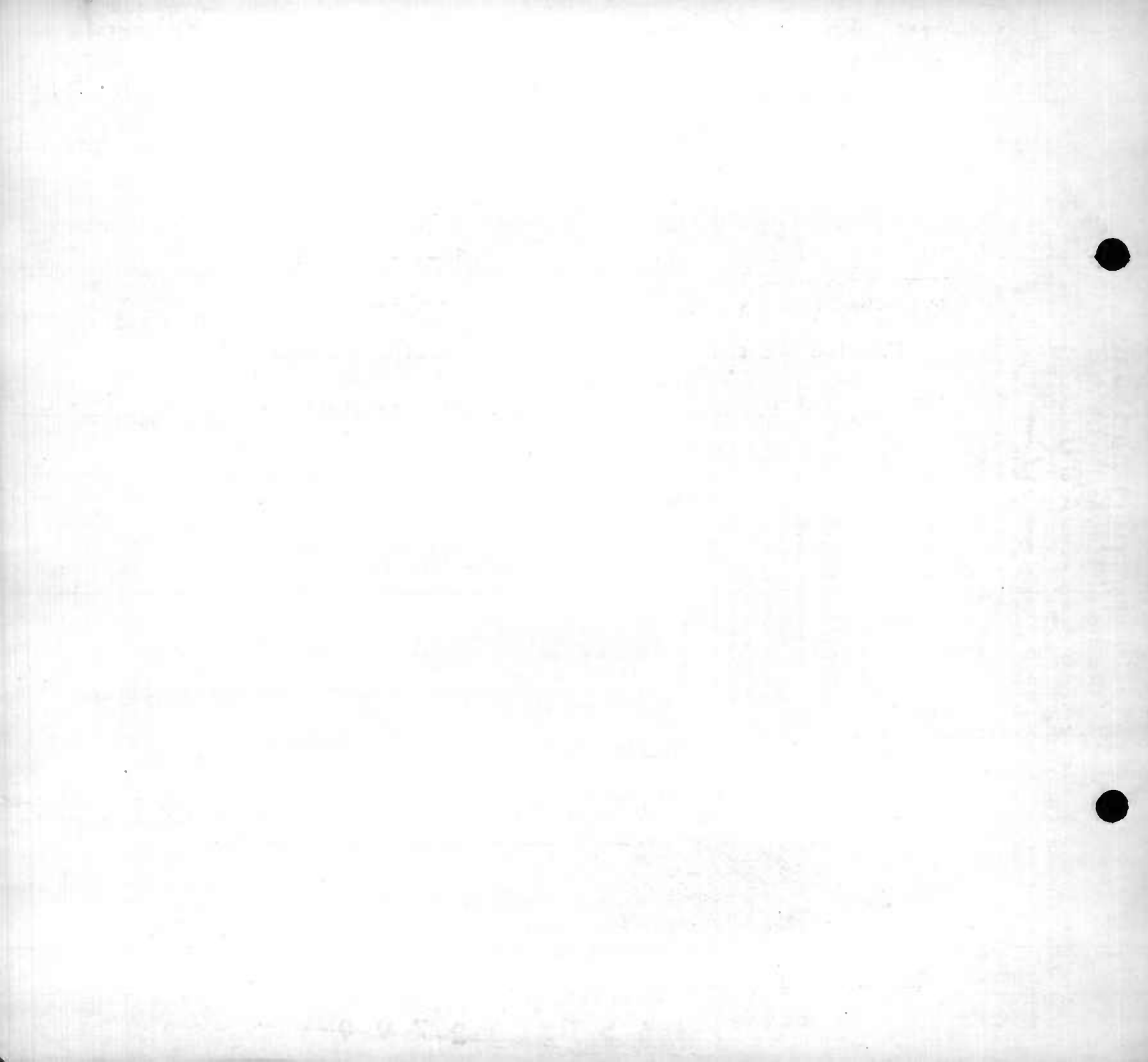
Letter from M.E. Office

5-4-65 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

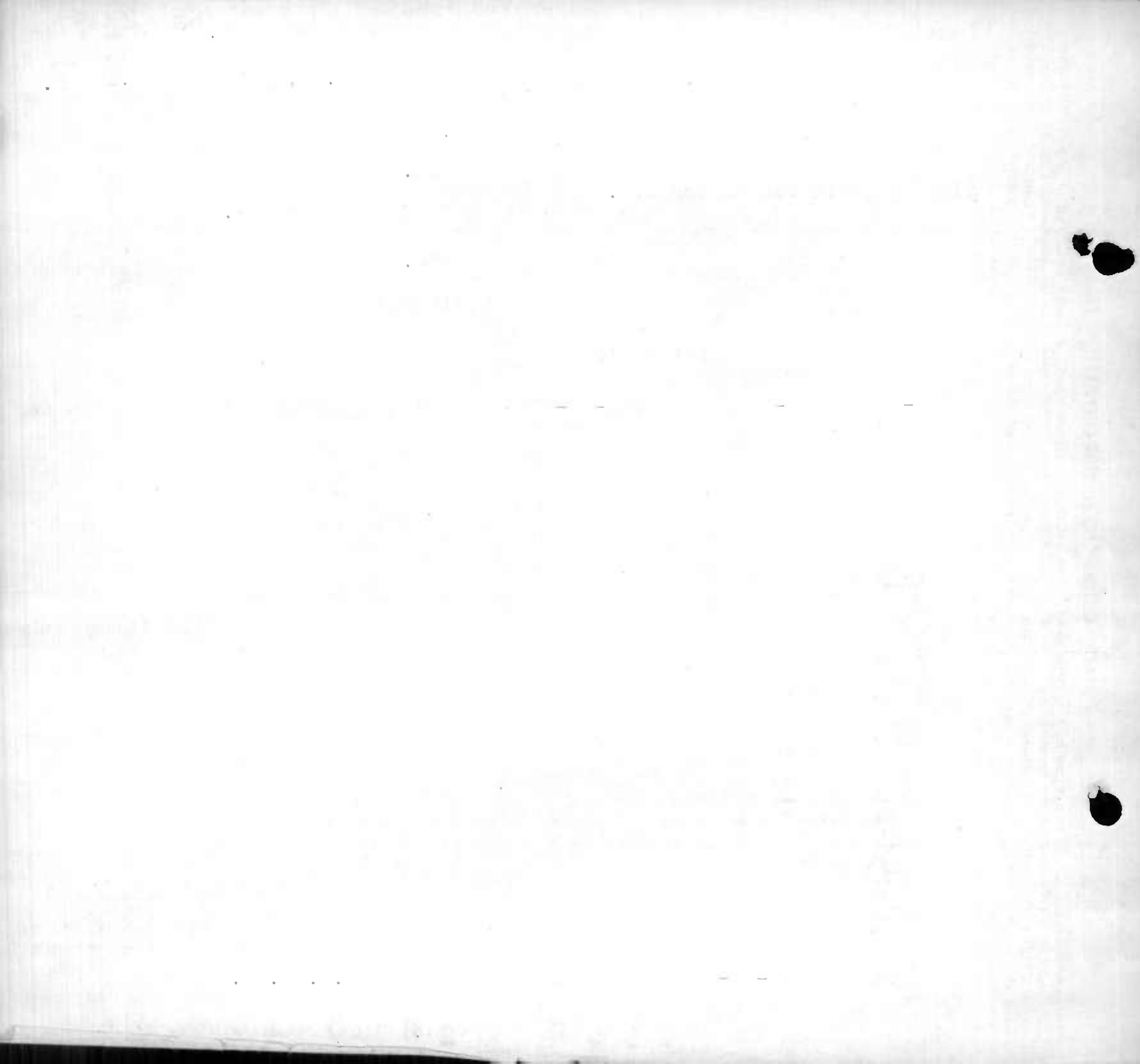
BIRTH NO. 65 2794				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2794	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HARRY GOLDMAN				2. DATE AND HOUR OF DEATH 3-13-65 11.15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL				A. STATE B. COUNTY MARYLAND 13-01			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY			
				D. STREET ADDRESS (If rural, give location) 717 LAKE DRIVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 10-10-82	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RET		11. BIRTHPLACE (State or foreign country) BALTO, MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MAURICE GOLDMAN				14. MOTHER'S MAIDEN NAME CAROLINE BUCKENHEIM			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1902		16. SOCIAL SECURITY NO.		17. INFORMANT DREERIC GOLDMAN		ADDRESS WHITE House WASH D.C.	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None				CAUSE OF DEATH (A) DUE TO Aspiration pneumonia (B) DUE TO Diabetes (C) DUE TO ASCVD		INTERVAL BETWEEN ONSET AND DEATH 3 days 20 yrs " "	
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (he) (this hospital) attended the deceased from 3/3/65 19 to 3/13/65 19 that (he) (we) last saw the deceased alive on 1055 PM 3/13/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. K. MEYER				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/13/65	
23C. PHYSICIAN'S NAME (Type) J. K. MEYER		23D. ADDRESS 530-A. N. BOND, BALTO.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/17/65	24C. NAME OF CEMETERY or CREMATORY Arlington National		24D. LOCATION (City, town, or county) (State) Arlington Va			
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Luis & Son		ADDRESS 3319 Olympia Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2795		CERTIFICATE OF DEATH		Registered No. 65 2795	
1. NAME OF DECEASED (Type or Print) <b>Mary A. Ashmenskas</b>				2. DATE AND HOUR OF DEATH <b>Mar. 14, 1965</b>		4.10 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>4515 Pennington Ave.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>25-05</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto. City</b> D. STREET ADDRESS (If rural, give location) <b>4515 Pennington Ave.</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>June 10, 1891</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Keturakis</b>				14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>			16. SOCIAL SECURITY NO. <b>220-30-4739</b>		17. INFORMANT ADDRESS <b>George Ashmenskas 4515 Pennington Ave</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) <b>391X I</b> <b>Cerebral Vascular Accident</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <del>this hospital</del> <sup>WE</sup> attended the deceased from <u>January</u> 19 <u>65</u> to <u>March</u> 19 <u>65</u> , that (I) <del>we</del> last saw the deceased alive on <u>13 March</u> 19 <u>65</u> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <del>did</del> (did not) view the body after death.									
23A. SIGNATURE <b>Mario J. Reda</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>15 March 1965</b>			
23C. PHYSICIAN'S NAME (Type) <b>MARIO J. REDA</b>				23D. ADDRESS M.D. <b>4016 RITCHIE HWY BALTO. 25, MD</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-18-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Cross</b>		24D. LOCATION (City, town, or county) (State) <b>A.A.Co.Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>		25B. NAME OF REGISTRAR <b>Polab E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Mon. S. Fialkowski</b>		ADDRESS <b>2007 Eastern Ave</b>			





FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>65 2796</b>		<b>CERTIFICATE OF DEATH</b>		65 2796	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Hicks, Thomas Hugh</b>		2. DATE AND HOUR OF DEATH <b>3-13-65</b> <b>5</b> <b>A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hosp.</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>XXXXXX, Cockeysville 53-00</b>			
		D. STREET ADDRESS (If rural, give location) <b>P.O. Box 174</b>			
5. SEX <b>Male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>3/30/1896</b>	9. AGE (In years last birthday) <b>68</b> <b>XXXX</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Conductor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
13. FATHER'S NAME <b>Hugh Hicks</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth A. Clark</b>		
16. SOCIAL SECURITY NO. <b>705-10-9406</b>			17. INFORMANT ADDRESS <b>Mrs. Dorothy H. Concannon ABOVE</b>		
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		(A) <b>Coronary occlusion</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Arteriosclerotic cardiovascular disease</b> DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-13-1965</b> to <b>3-13-1965</b> , that (I) (we) last saw the deceased alive on <b>3-13-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harold F. Marsal</b>				23B. DATE SIGNED <b>3-13-65</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <b>Maryland General Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-16-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Jessop Methodist Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Sparks, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Brooks Funeral Service, Towson, Md. 21204</b>	

Handwritten notes, possibly a list or index, with some legible words like "W. 1000" and "1000-1000".

Handwritten notes at the bottom of the page, including a large "X" and some illegible text.

# FUNERAL DIRECTOR: IMPORTANT

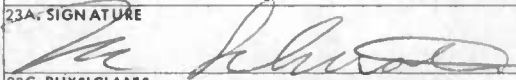
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2797</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 2797</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Burl Dean WADE</b>		2. DATE AND HOUR OF DEATH <b>3-12-65 16.45 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Hanford</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Fallston 62-00</b>	
5. SEX <b>M</b> 6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>9-6-57</b> 9. AGE (in years last birthday) <b>7</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Leonard W. WADE</b>		14. MOTHER'S MAIDEN NAME <b>Ruby Cox</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Information obtained from chart -</b> ADDRESS	
18. <b>200.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Lymphosarcomatosis</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2-25-65</b> 19 to <b>3-12-65</b> 19, that (I) (we) last saw the deceased alive on <b>3-12-65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Carlos Abel</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-12-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARLOS ABEL</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-15-65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Grace Methodist Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Falls Rd., Cockeysville, Md.</b>		24E. STATE <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Brooks Funeral Service, Towson, Md. 21204</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2798</u>	
BIRTH NO. <u>65 2798</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Adam Smith Sr.</u>		2. DATE AND HOUR OF DEATH <u>3-12-65</u> <u>8:00 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2605</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland #21224</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>421 South Bonsal Street</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-25-73</u>	9. AGE (In years last birthday) <u>91</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>? Smith</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-07-8990</u>		17. INFORMANT ADDRESS <u>RECORDS: B.C.H. 4940 Eastern Avenue #21224</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ostehenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardio Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 Years</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Myocardial Infarction</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-5-</u> <u>19 65</u> to <u>3-12</u> <u>19 65</u> , that (I) (we) lost saw the deceased alive on <u>3-12</u> <u>19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3-12-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Marvin Schuster</u>		23D. ADDRESS M.D. <u>4940 Eastern Avenue #21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>3-15-65</u>	24C. NAME of CEMETERY or CREMATORY <u>Schwartz Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>6115 O'Donnell St. Balto. 24, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1965</u>		25B. NAME OF REGISTRAR <u>Charles J. Giller</u>		25C. FUNERAL DIRECTOR ADDRESS <u>6224 Eastern Ave. Balto. Md. 21224</u>	

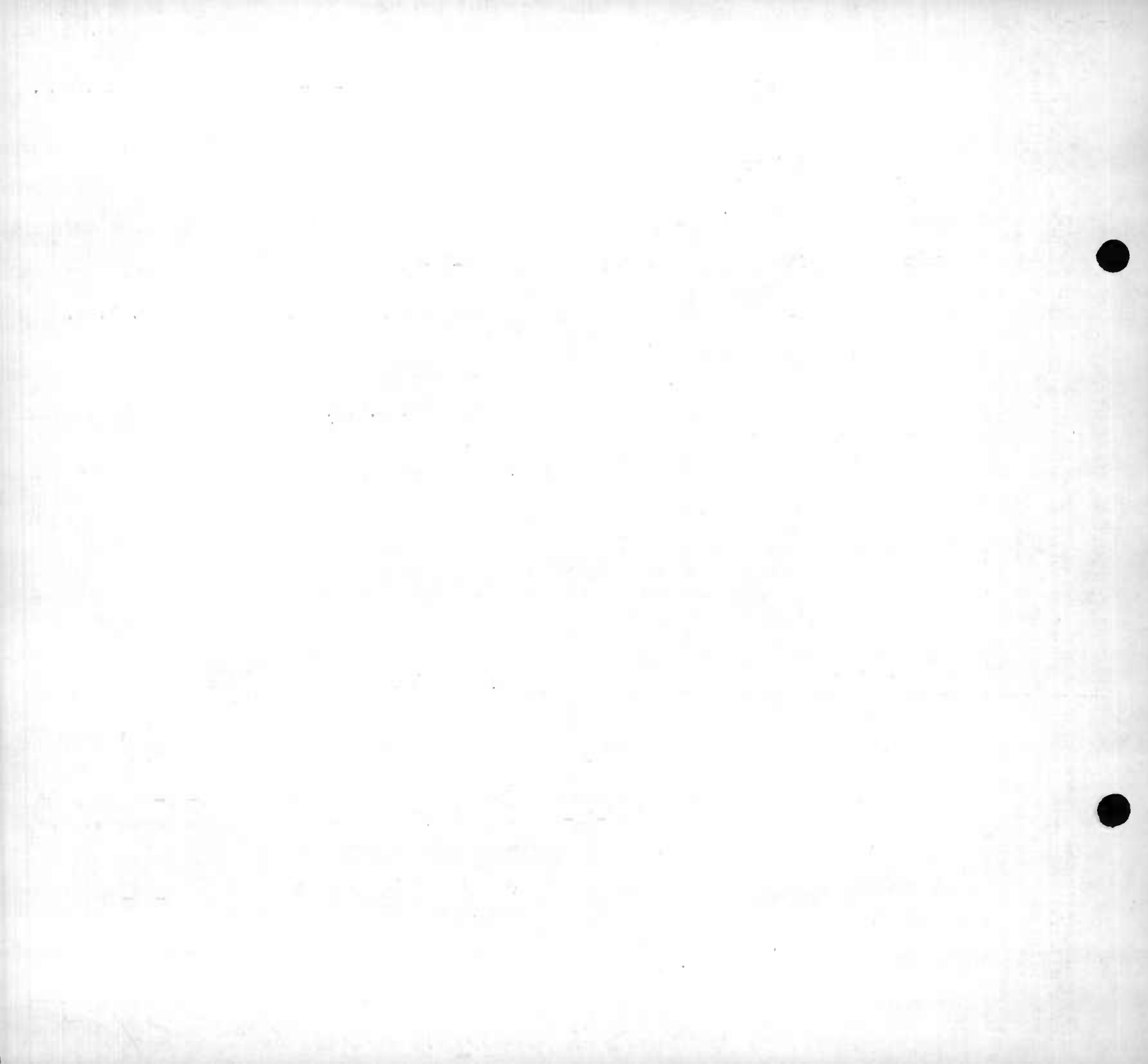


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. _____				
BIRTH NO. <b>65 2799</b>									
M.E. CASE NO. _____									
1. NAME OF DECEASED (Type or Print) <b>William Boyd</b>					2. DATE AND HOUR OF DEATH <b>3-13-65 10:00 P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>					A. STATE <b>Maryland</b>				
					B. COUNTY _____				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				
					D. STREET ADDRESS (If rural, give location) <b>3100 Magnolia Avenue #</b>				
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>5-18-07</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ship Runner</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Shipping</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Boyd</b>			14. MOTHER'S MAIDEN NAME <b>Martha Lodman</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. _____			17. INFORMANT ADDRESS <b>RECORDS: B.C.H. 4940 Eastern Avenue #21224</b>						
18. <b>451X I</b> CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b>				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Dissecting Aorta</b>									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) DUE TO</b>									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>(C) DUE TO</b>									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>3-10</b> 19 <b>65</b> to <b>3-13-</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3-13-</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Dr. Robert Cooke</b> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>3-13-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Robert Cooke</b>					23D. ADDRESS <b>4940 Eastern Avenue #21224</b>				
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-17-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Starkey</b>		25C. FUNERAL DIRECTOR <b>John J. Lohan + Son Inc.</b>		ADDRESS <b>Baltimore</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2800				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2800	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Irene A. Yeagle</u>				2. DATE AND HOUR OF DEATH <u>March 12, 1965</u>   <u>1:45 p.</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>606 Harding Place</u>				A. STATE <u>Maryland</u> B. COUNTY <u>13-06</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>606 Harding Place</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 27, 1898</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>John Keller</u>			14. MOTHER'S MAIDEN NAME <u>Eldorado Reigle</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Eston D. Yeagle</u>		
					ADDRESS <u>606 Harding Place</u>		
18. <u>260X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <u>myocardial infarction</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>five minutes</u>	
				(B) <u>generalized arteriosclerosis</u> DUE TO			
				(C) <u>diabetes mellitus</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>April 17th</u> 19 <u>57</u> to <u>March 12</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>March 1</u> , 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>E. Ellsworth Cook</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3/12/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. Ellsworth Cook MD.</u>				23D. ADDRESS <u>2431 Maryland Avenue</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/16/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park</u>		24D. LOCATION (City, town, or county) (State) <u>Windsor Mill Rd, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Galtman</u>		25C. FUNERAL DIRECTOR <u>Quentin E. Honnan</u>		ADDRESS <u>3818 Roland Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2801		CERTIFICATE OF DEATH		Registered No. 65 2801	
1. NAME OF DECEASED (Type or Print) <b>Fay Dean</b>				2. DATE AND HOUR OF DEATH <b>March 14, 1965 11:45 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE CORRECTED 4-2-65</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1520 Leslie Road</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>12-2-90</b>	9. AGE (In years last birthday) <b>73 74</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chipper</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Ship Constr.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William W. Dean</b>				14. MOTHER'S MAIDEN NAME <b>Sally Dixon</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>166-14-4271</b>		17. INFORMANT ADDRESS <b>RECORDS-BCH-4940 Eastern Avenue- #21224</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>493X I</b> (This does not mean the mode of dying, e.g., heart failure, osteoma, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>				CAUSE OF DEATH (A) DUE TO <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO					
				(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Parkinson's Disease</b>						<b>years</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>10-28 19 65</b> to <b>3-14 19 65</b> , that (I) (we) last saw the deceased alive on <b>3-14 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Dr. Robert Cooke</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-14-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. Robert Cooke</b>				23D. ADDRESS M.D. <b>BCH-4940 Eastern Avenue-#21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/15/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenmount Crematorium</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>		25B. NAME OF REGISTRAR <b>Brooks Bradley, Inc.</b>		25C. FUNERAL DIRECTOR <b>Brooks Bradley, Inc.</b>		ADDRESS <b>Balto. Md.</b>			

Letter from B.C.H.

4-2-65 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2802				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2802	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>MRS. Ada B. RIES</i>				2. DATE AND HOUR OF DEATH <i>3/15/65 7:30 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>MARYLAND GENERAL HOSPITAL</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>25-04</i>			
5. SEX <i>F</i> 6. RACE <i>W</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>				8. DATE OF BIRTH <i>10-16-89</i>		9. AGE (In years lost birthday) <i>75</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>LEIS REINHARDT</i>			
14. MOTHER'S MAIDEN NAME <i>EMMA HARRISON</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Hospital Admission Sheets</i> ADDRESS <i>Not given by patient</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Cerebrovascular Accident</i> DUE TO <i>(Cerebral Thrombosis +/or Embolus).</i> (B) <i>Arteriosclerotic Heart Disease</i> DUE TO (C) <i>Diabetes Mellitus.</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>25 yrs.</i>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this <u>hospital</u> ) attended the deceased from <i>Feb 27</i> 19 <i>65</i> to <i>March 15</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>March 15</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Steve G. Valle</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>March 15, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>NIEVA G. VALLE</i>				23D. ADDRESS <i>Maryland General Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>3/18/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Landow Park</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 16 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Stalder</i>		25C. FUNERAL DIRECTOR <i>McCully</i>		25D. ADDRESS <i>237 Latrobe Ave</i>	

Section  
The first section  
of the road is  
about 1/2 mile  
long.

At the end of the road  
there is a small  
pond.

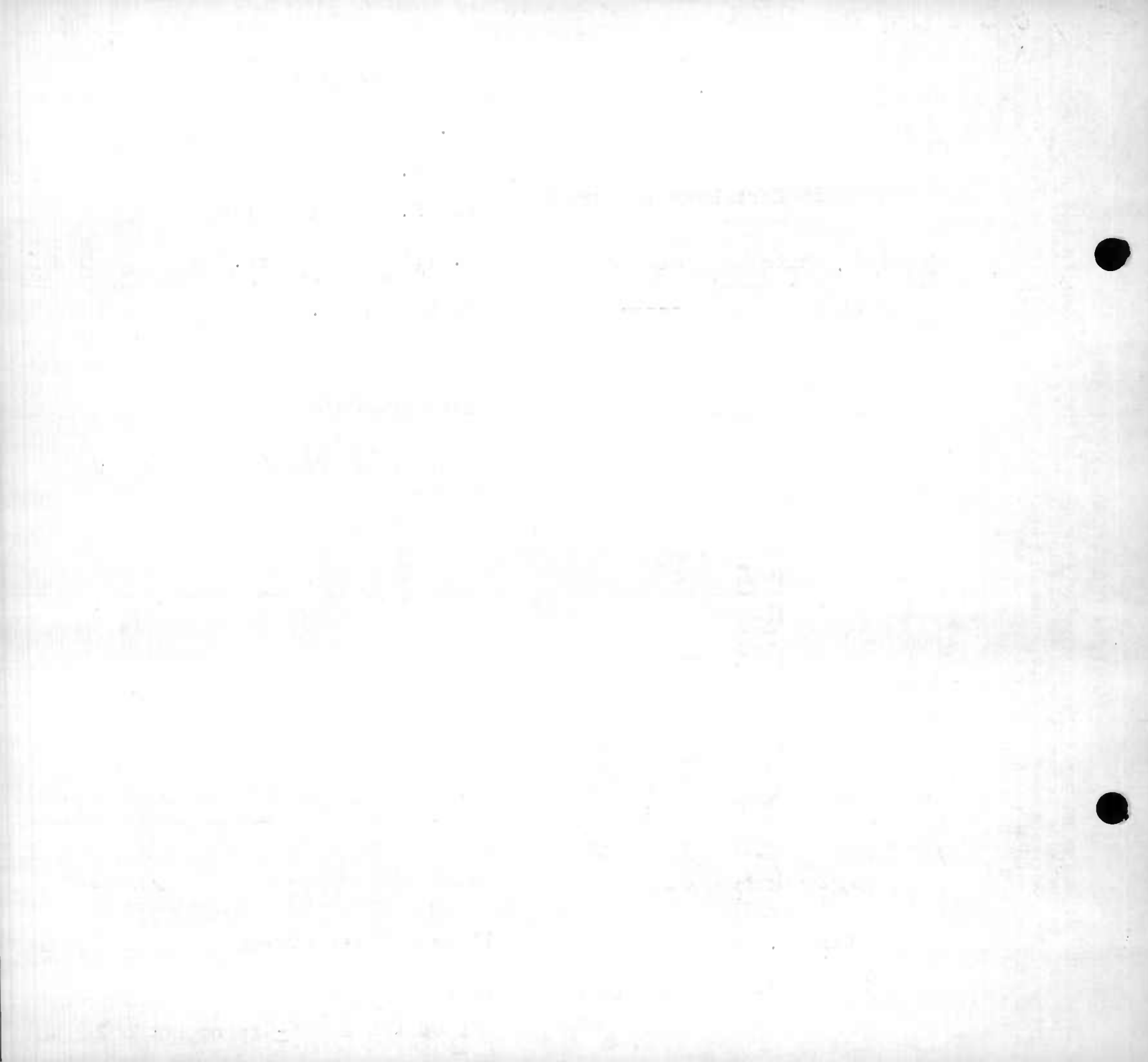
Part of the  
road is paved.



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 2803</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">65 2803</span>		<b>CERTIFICATE OF DEATH</b>			
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">MARGARET M. COLE</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">3/10/65</span>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <span style="font-size: 1.2em;">436 East Lanvale Street</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.5em;">12-05</span> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Balto.</span> <b>D. STREET ADDRESS</b> (If rural, give location) <span style="font-size: 1.2em;">436 E. Lanvale Street</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED, NEVER MARRIED</b> WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Widowed</span>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Aug. 31, 1875</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">89 yrs.</span>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">-----</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
<b>13. FATHER'S NAME</b>			<b>14. MOTHER'S MAIDEN NAME</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Miss Mary Cole</span>	
<b>18. 422-1 I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) <span style="font-size: 1.2em;">Arteriosclerotic Cardio-Vascular Disease</span> DUE TO (B) _____ DUE TO (C) _____		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">5 yrs.</span>	
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-8</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">3-10</span> 19 <span style="font-size: 1.2em;">65</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3-10</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Philip D. Flynn</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">3-12-65</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type)		<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">11 East Chase Street</span>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)		<b>24B. DATE</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b>	
<span style="font-size: 1.2em;">Burial</span>		<span style="font-size: 1.2em;">3/13/65</span>		<span style="font-size: 1.2em;">Baltimore Cemetery</span>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b>		<b>25B. NAME OF REGISTRAR</b>		<b>25C. FUNERAL DIRECTOR</b>	
<span style="font-size: 1.2em;">MAR 15 1965</span>		<span style="font-size: 1.2em;">Robert E. Taylor M.D.</span>		<span style="font-size: 1.2em;">WIEDEBELD &amp; SON</span>	
<b>25D. ADDRESS</b>		<span style="font-size: 1.2em;">Greenmount &amp; 22 ND</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>65-05789</u>		65 2804		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 2804</u>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Baby Linda Slaughter</u>				2. DATE AND HOUR OF DEATH <u>3/12/65</u> <u>11:50 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Lutheran Hospital of Maryland</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1308 Meadowville Rd.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>3/12/65</u>	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: <u>21</u>	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLARENCE SLAGHT</u>				14. MOTHER'S MAIDEN NAME <u>PHYLLIS CUNNINGHAM</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>CLARENCE SLAGHT 1308 MEADOWVILLE RD</u>			
18. <u>762.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <u>Brain damage</u> DUE TO (B) <u>pre &amp; post natal anoxia</u> DUE TO (C)  INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/12</u> 19 <u>65</u> to <u>3/12</u> 19 <u>65</u> . that (I) (we) last saw the deceased alive on <u>3/12/65</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Forrest L. Leal</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/12/65</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-15-1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>OLD YELLOW CREEK CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>MIDDLESBORO KENTUCKY</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>WEBER FUNERAL HOME 5311 EDMONSON AVE</u>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2805				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2805	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				ALLEN, HOWARD M.			
2. DATE AND HOUR OF DEATH				3/14/65 2:35 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
CERTIFICATE CORRECTED 3-18-65				A. STATE New Jersey			
B. CITY OR TOWN (If outside city limits, write RURAL and give township)				New Gretna			
C. STREET ADDRESS (If rural, give location)				None			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		White		Single		1/17/87	
9. AGE (In years lost birthday)		10. CITIZEN OF WHAT COUNTRY?		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
78		USA		New Gretna, New Jersey		USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
Oysterman				Oyster Business			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Edward Allen				Margaret Geraw			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
Yes				None			
2/23/18 to 6/12/19				VA Hospital, Baltimore, Md. 21218			
17. INFORMANT				ADDRESS			
CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Adenocarcinoma of the Prostate			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				DUE TO with Metastases			
ANTECEDENT CAUSES				DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II				Chronic Pyelonephritis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Cerebral Arteriosclerosis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No		No		No		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
No		No		No		No	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		21G. HOW DID INJURY OCCUR?		21H. HOW DID INJURY OCCUR?	
While At Work		While At Work		While At Work		While At Work	
22. I certify that (h) (this hospital) attended the deceased from 3/24 1964 to 3/13/65 that (l) (we) last saw the deceased alive on 3/14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (h) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
RALPH H. TWINING				3/14/65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
RALPH H. TWINING				Veterans Administration Hospital, Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3/17/65		Miller Cemetery		New Gretna, New Jersey	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 16 1965		R. B. E. Staley, M.D.		W. L. E. Johnson, M.D.		8521 Loch Raven	

Letter from out-of-state Funeral Director  
Wood Funeral Home, Tuckerton, N.J. 3-18-65 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2806				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2806	
1. NAME OF DECEASED (Type or Print) <b>Thomas Austin</b>				2. DATE AND HOUR OF DEATH <b>15 March 65</b>   <b>4:30 A. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ind.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>611 W. Franklin</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widower</b>	8. DATE OF BIRTH <b>9-15-1891</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Enfield, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Eben Austin</b>				14. MOTHER'S MAIDEN NAME <b>Hannie Trichason</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>224-18-0228</b>		17. INFORMANT ADDRESS <b>Charles Pittman same</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>331X I</b> <b>Cerebral vascular accident</b> (A) DUE TO  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH <b>~ 30 hours</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>13 March</b> <b>19 65</b> to <b>15 March</b> <b>19 65</b> , that (I) (we) last saw the deceased alive on <b>15 March</b> <b>19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Richard P. Norgaard</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>15 March 65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard P. Norgaard</b> M.D.				23D. ADDRESS <b>University Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-20-65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Richmond, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Charles R. Law 802 Madison Ave.</b>			





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65 2807

BALTIMORE CITY HEALTH DEPARTMENT

65 2807

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>THOMAS J. CROPPER, Jr</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>March 14, 1965 1:45 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Mercy Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 12-06</b> D. STREET ADDRESS (If rural, give location) <b>40 E. 25th Street</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>July 24, 1905</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi Driver</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Thomas J. Cropper, Sr.,</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Carbach</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b>			16. SOCIAL SECURITY NO. <b>214-03-0056</b>		17. INFORMANT ADDRESS <b>Edward C. Cropper, 3075 Bero Road, Baltimore 27</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple Traumatic Injuries.</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO							INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Monument &amp; Ensor Streets 10-02</b>			
21D. TIME OF INJURY (APPROX.) <b>3 14 '65 A</b>		21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Taxi driver in auto-auto accident.</b>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Petty</i> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3/14/65</b>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23B. DATE <b>3-17-65</b>		23C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>		24B. NAME OF REGISTRAR <i>Robert E. Farley</i>		24C. FUNERAL DIRECTOR <b>Wm. Cook, Inc., 1217 St. Paul Street, 21202</b>		ADDRESS	

WALLEY PROPOSE

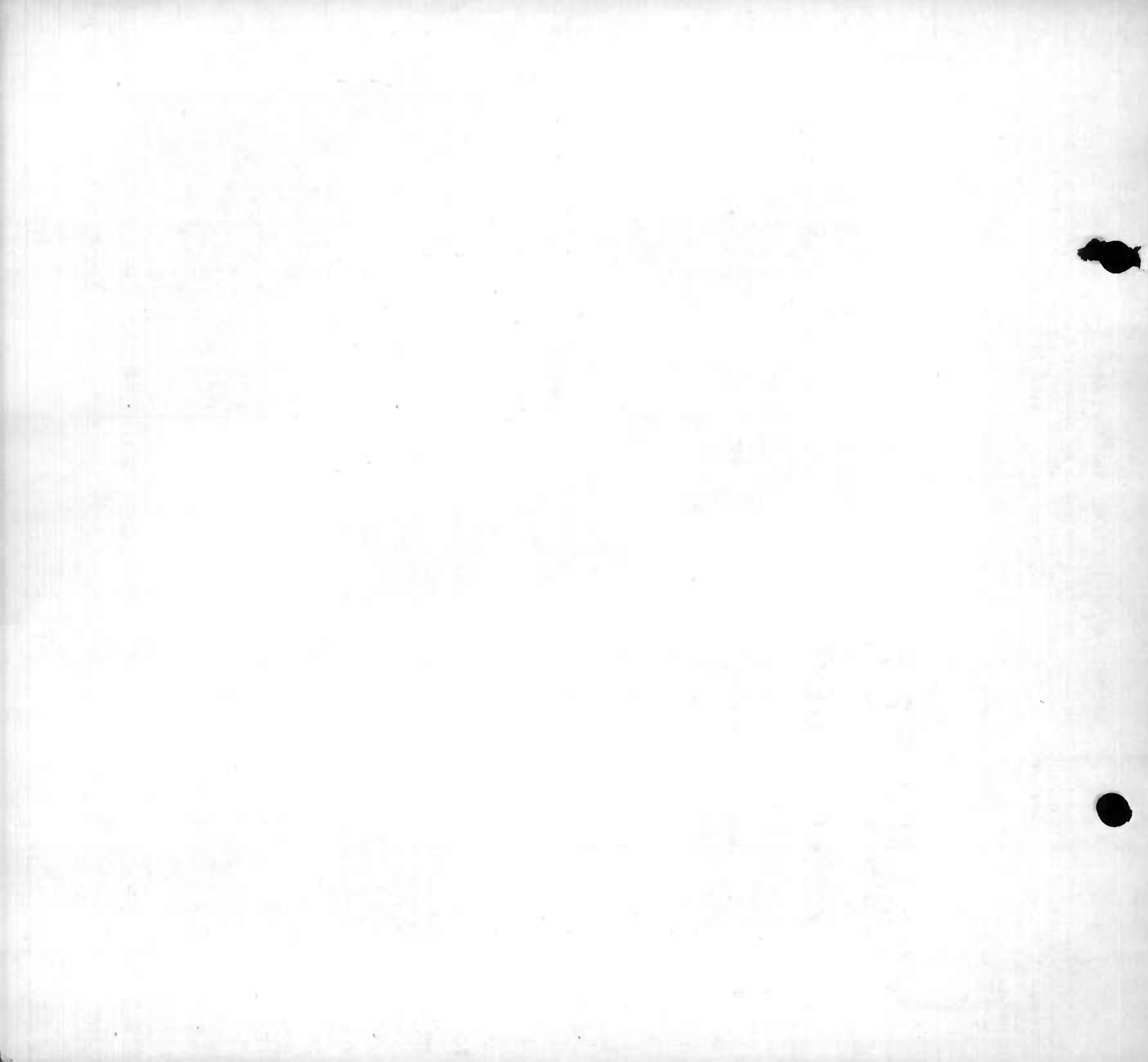
PROPOSAL

Chris J. [Signature]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

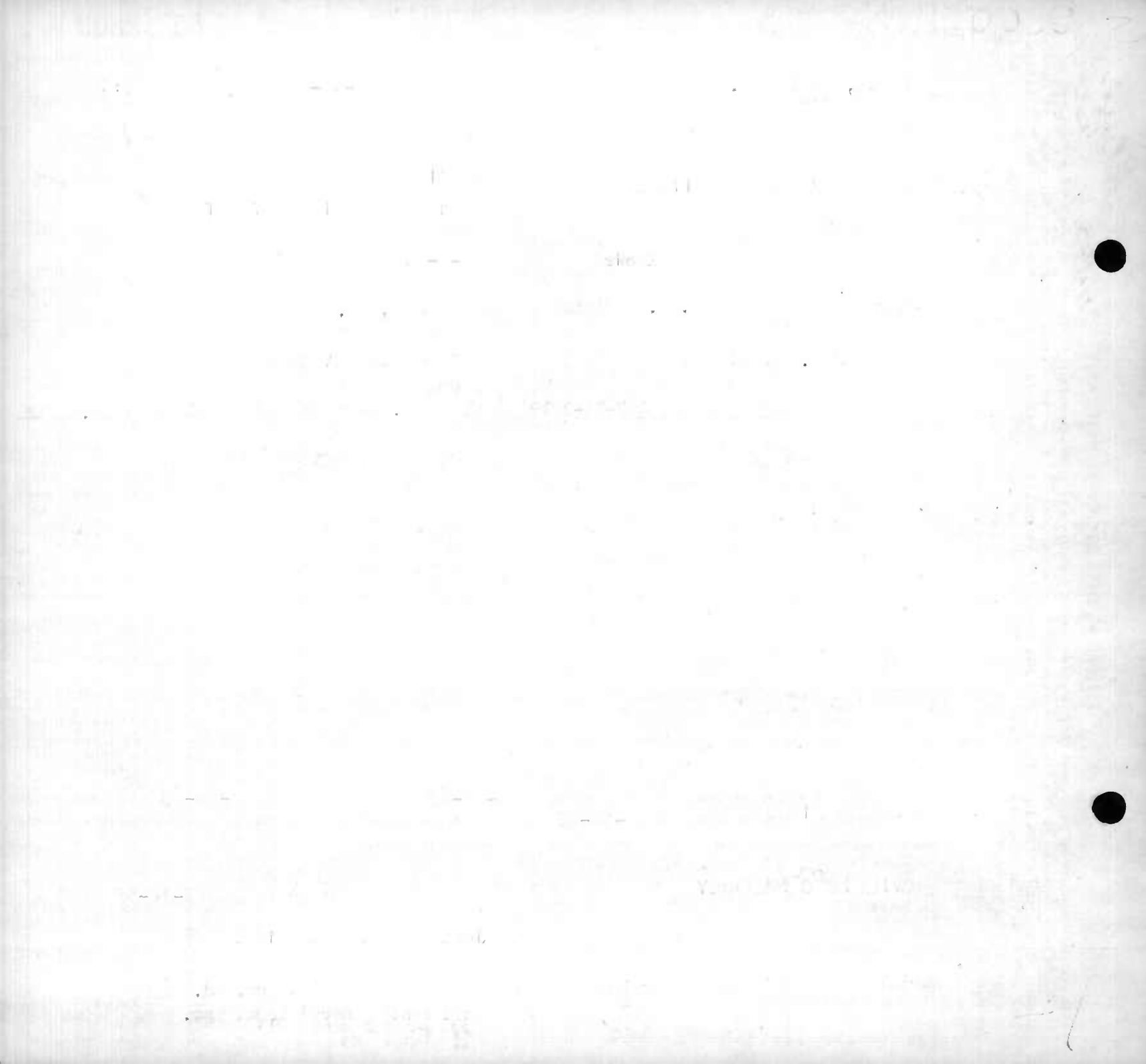
BIRTH NO. 65 2808				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2808	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH		9 a.	
1. NAME OF DECEASED (Type or Print) <i>Marie Harris</i>				3-13-65			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
6107 Marlora Road		Baltimore, Maryland 21212		Maryland		27-38	
5. SEX				6. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White		6-12-87		77	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Widowed				Maryland		USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
Seamstress				Clothier			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Frank Vales				Marie Base			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				217 26 5733		Marie L. Roppelt 6107 Marlora Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(A) A-S-C-V - Disease		5 yrs.	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from August 19 1960 3-13-65 19 that (I) (we) lost saw the deceased alive on 3-11-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
M-B Davis M.D.				3/15/65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
M-B. Davis M.D.				6800 Morningstar Dr - Dundasville			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3-16-65		Parkwood Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 16 1965		Philip E. Farley M.D.		Philip E. Grach		1211 Chesaco Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2809		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2809	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) SCHUCH, ADOLPH F.			3-12-65 9:12AM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 7-01		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 2821 EAST MADISON STREET		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9-8-91	9. AGE (in years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		10B. KIND OF BUSINESS OR INDUSTRY Wm. F. Lukitis		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME ADOLPH P. SCHUCH		
14. MOTHER'S MAIDEN NAME FLORENCE NEUBERGER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 217-14-2019			17. INFORMANT (Print) Gladys V. Gunther 4631 Marble Hall Rd. #12		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-12-65 19 to 3-12-65 19, and that (I) (We) last saw the deceased alive on 3-12-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE WILLIS C. MADDREY				23B. DATE SIGNED 3-12-65	
23C. PHYSICIAN'S NAME (Type) W. Maddy				23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/65		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Cemetery	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. MAR 16 1965		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		24H. ADDRESS 331 E. Enoch Ave #13		24I. DATE 3-12-65	

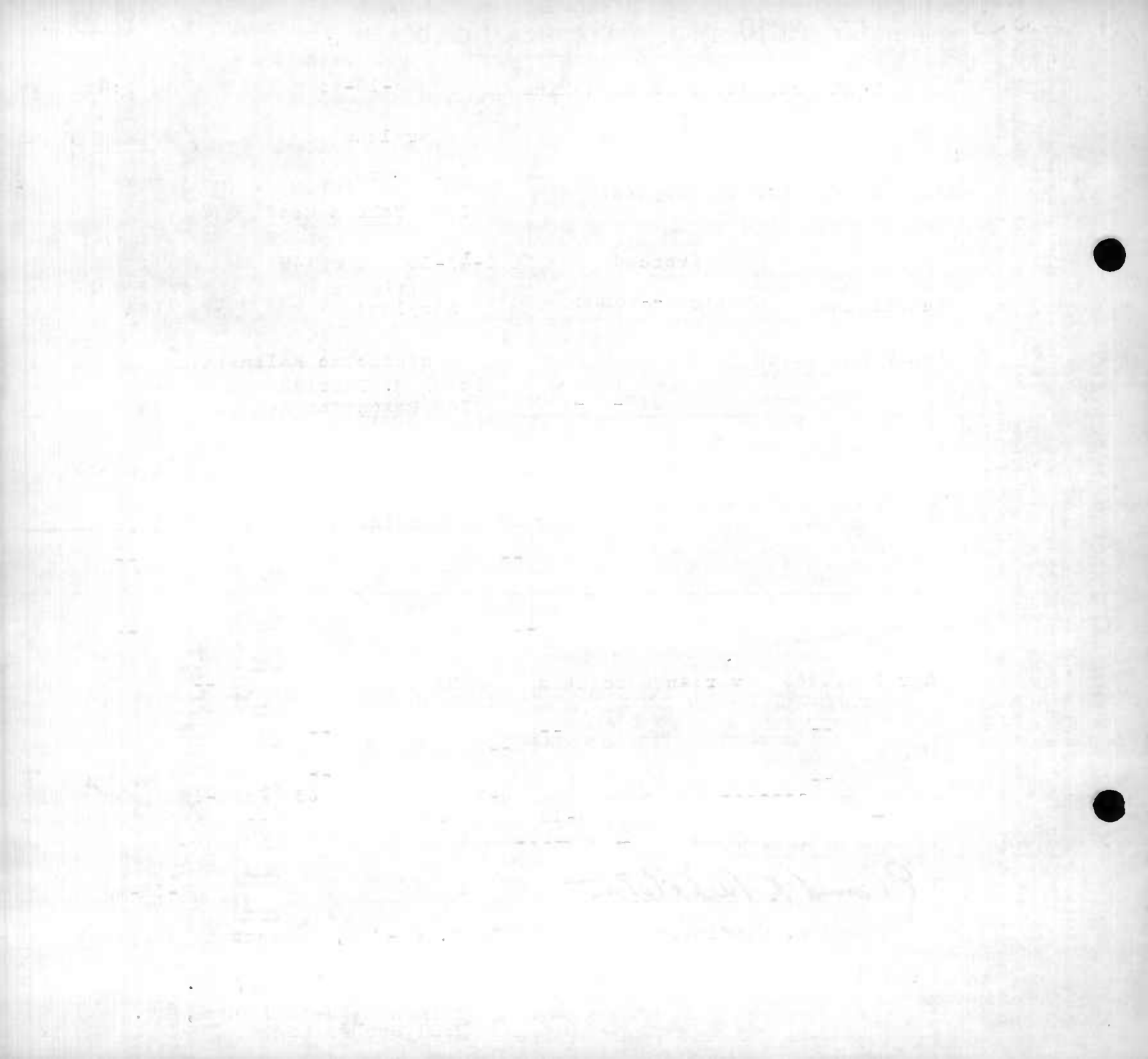




# FUNERAL DIRECTOR: IMPORTANT

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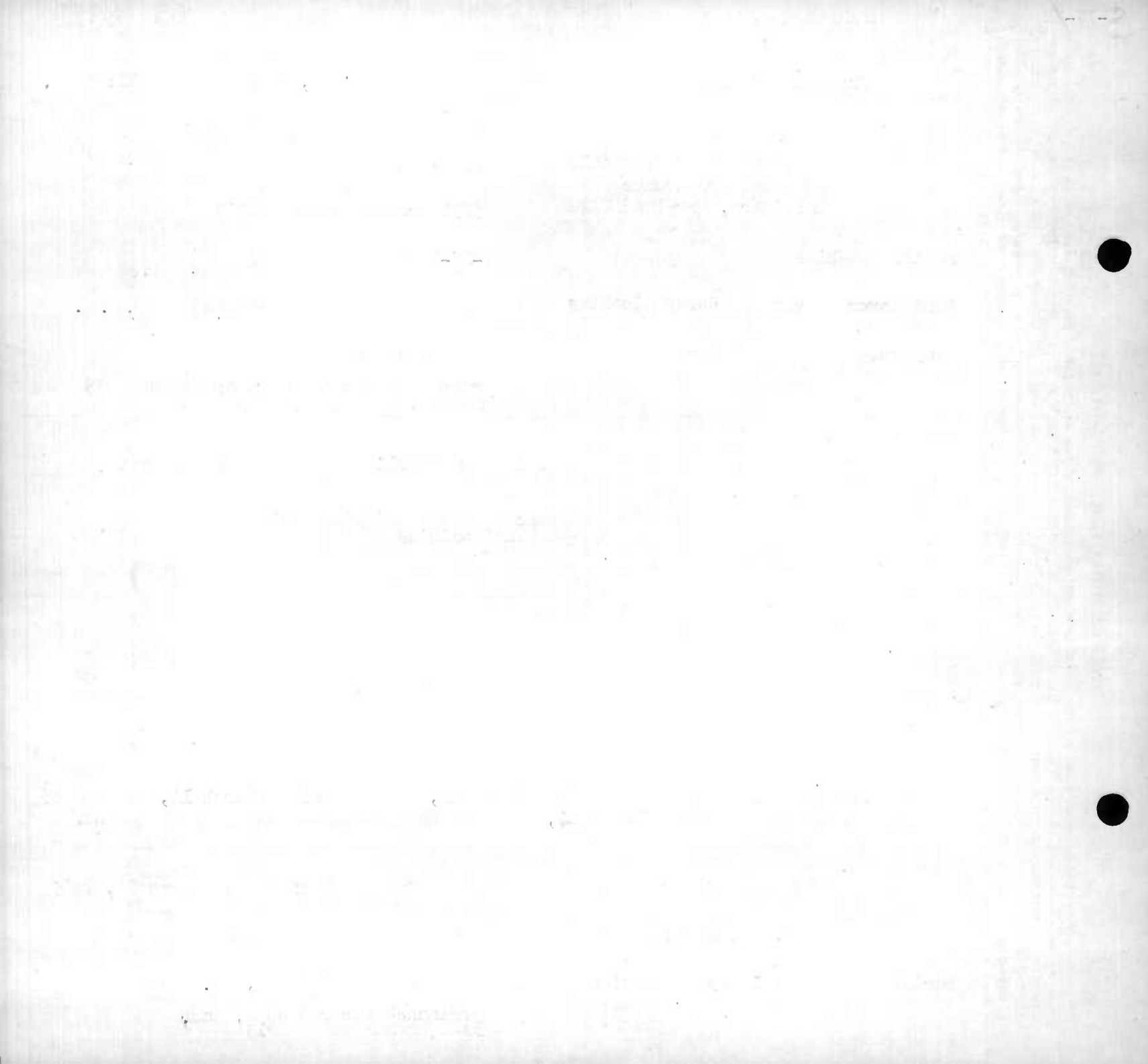
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 2810	
BIRTH NO. 65 2810		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) McIntyre, Gertrude Josephine		2. DATE AND HOUR OF DEATH 3-13-65 5:45 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland University Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1704 Yakoma Road #34			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 1-15-16	9. AGE (In years last birthday) 49	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		11. PLACE OF BIRTH (State or foreign country) Baltimore Maryland
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		10B. KIND OF BUSINESS OR INDUSTRY Valle Vivienne		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Marshalek	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-03-6893		17. INFORMANT Frank H. Parrish		ADDRESS 3740 Bonnevill Avenue #13	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intestinal Obstruction DUE TO 2 months II ANTECEDENT CAUSES Ovarian Carcinoma DUE TO 2 years DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. -- III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. --				INTERVAL BETWEEN ONSET AND DEATH 2 months 2 years --			
19A. DATE OF OPERATION April 3, 1963		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ovarian Carcinoma		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? --	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) --		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) --		21C. WHERE DID INJURY OCCUR? --		21D. TIME OF INJURY (APPROX.) --	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? --		22. I certify that (I) (this hospital) attended the deceased from 4-2-19-63 to 3-13-19-65, that (I) (we) last saw the deceased alive on 3-13-19-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Edmund B. Middleton M.D.				23B. DATE SIGNED 3-13-65		23C. PHYSICIAN'S NAME (Type) Edmund B. Middleton M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/65		24C. NAME of CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965		25B. NAME OF REGISTRAR Robert E. Stachurski		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 2331 Brehms Lane	



# FUNERAL DIRECTOR: IMPORTANT

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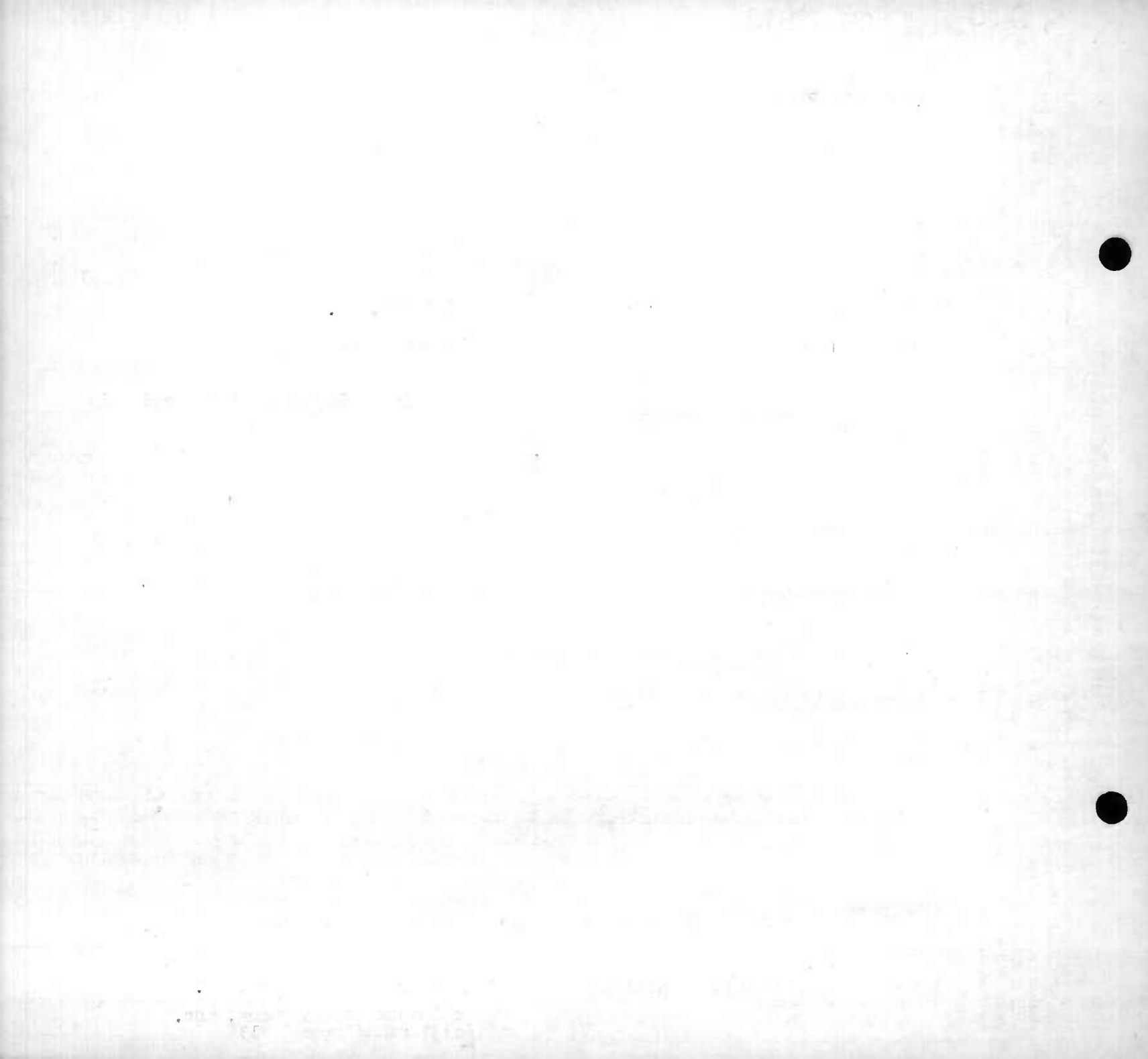
BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. <b>65 2811</b>		REGISTERED NO. <b>65 2811</b>	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Frances Safranek</b>			2. DATE AND HOUR OF DEATH <b>March 14, 1965 11:20 A. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>5030 Erdman Avenue 21205</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>9-23-1880</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hand Sower Sewer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Carey Clothing</b>	11. BIRTHPLACE (State or foreign country) <b>Bohemia (Czechoslovakia)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown Rach</b>			14. MOTHER'S MAIDEN NAME <b>Un known</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Frances Shiner 5030 Erdman Avenue #13 21205</b> <b>RECORDS: BCH 4940 Eastern Avenue 21224</b>		
18. <b>460X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>Pulmonary Emboli</b> DUE TO (B) <b>Venous Stasis and Bilateral</b> DUE TO <b>Varicosities</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 11, 1965</b> to <b>March 14, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 14, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert Cooke</b>			23B. DATE SIGNED <b>March 14, 1965</b>		
23C. PHYSICIAN'S NAME (Type) <b>Robert Cooke</b>			23D. ADDRESS <b>4940 Eastern Avenue 21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/18/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Bohemian National Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>		25B. NAME OF REGISTRAR <b>Robert Cooke</b>		25C. FUNERAL DIRECTOR <b>Schlimmer Funeral Home, Inc. 3331 Brehms Lane #13</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2812</b>	
BIRTH NO. <b>65 2812</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>March 13-1965 350 pm</b> M.	
1. NAME OF DECEASED (Type or Print) <b>King, Richard W</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>X</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4014 South Clare Rd</b>	
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never married</b>	8. DATE OF BIRTH <b>13-3-30</b>
9. AGE (In years last birthday) <b>35</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WALTER KING</b>		14. MOTHER'S MAIDEN NAME <b>AGNES MARKER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT (Mother) <b>Agnes King</b>		ADDRESS <b>4014 South Clare Road #13</b>	
18. <b>334X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebral Palsy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>35 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this <b>X</b> hospital) attended the deceased from <b>2.26 1965</b> to <b>3.13. 65</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>259 3.13. 19 65</b> and that in (my) ( <b>X</b> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <b>X</b> ) (did) (did not) view the body after death.			
23A. SIGNATURE <b>W. Maxson</b>		23B. DATE SIGNED <b>3.13. 65</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/16/65</b>	
24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Stokely</b>	
25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3831 Brehms Lane #13</b>	

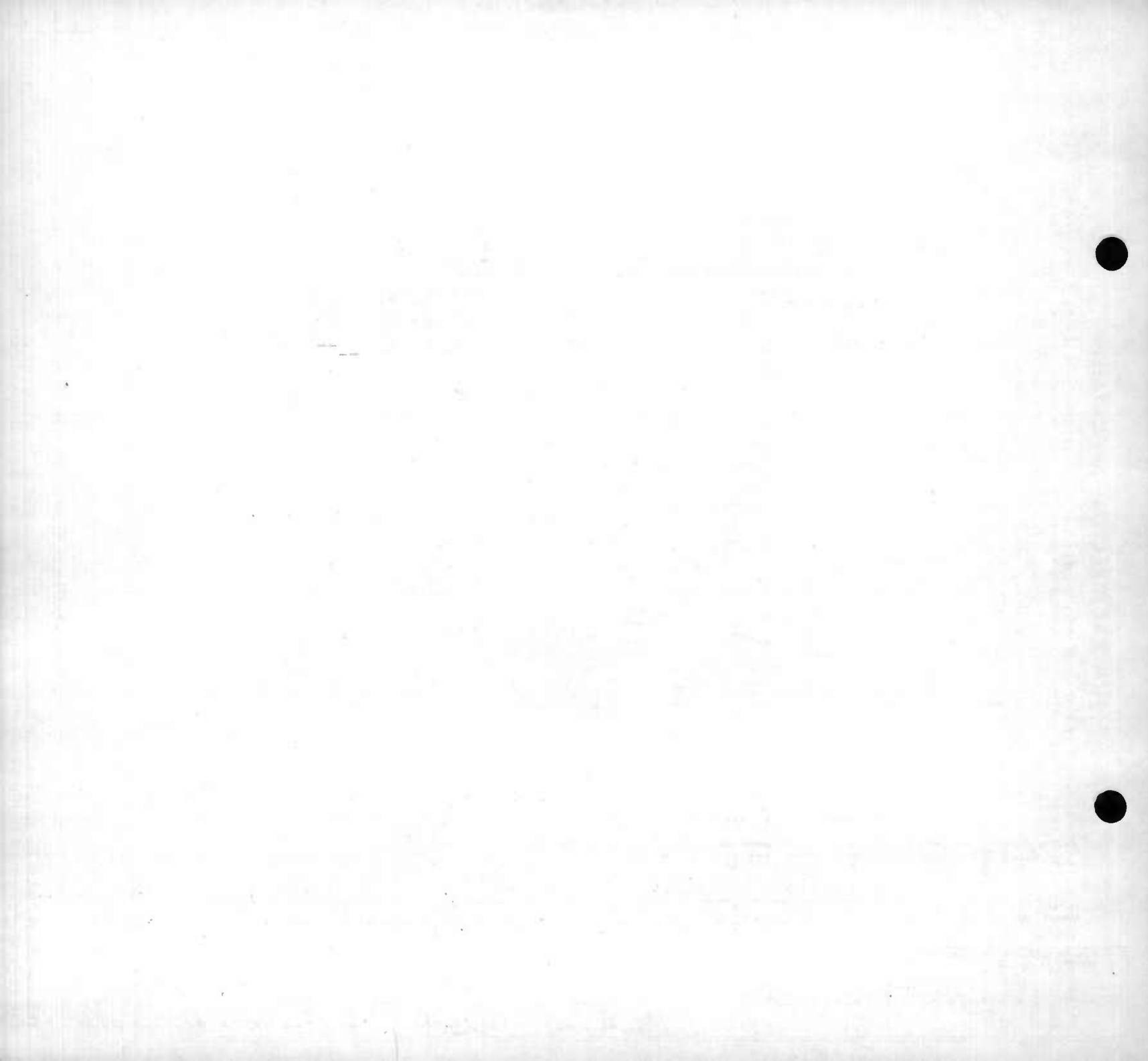


# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2813</u>	
BIRTH NO. <u>65 2813</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>CLEMENTINE DI MAGGIO</u>		2. DATE AND HOUR OF DEATH <u>3-14-65 at 11 A.M.</u> <u>11. A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>27-03</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>2716 Southern Ave</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>2716 Southern Ave</u>			
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W</u>	B. DATE OF BIRTH <u>1-12-1880</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>
13. FATHER'S NAME <u>Joseph Ferrer</u>			14. MOTHER'S MAIDEN NAME <u>Maria Ma Melucci</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218090569D</u>	17. INFORMANT <u>SON</u> ADDRESS <u>3416 Woodstock Ave</u>		
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Acute Myocardial Infarction</u> DUE TO (B) <u>Coronary arteriosclerosis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hysterectomy</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fibroma</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-14</u> <u>1965</u> to <u>3-14</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>3-14</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sebastian Russo</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3-14-1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>SEBASTIAN Russo</u>		23D. ADDRESS M.D. <u>5017 Harford Road Baltimore Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>3/17/65</u>	24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc 5305 Harford Road</u>	





G. 652

65 2814 BALTIMORE CITY HEALTH DEPARTMENT 65 2814

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ARTHUR T. GRIMES 2. DATE AND HOUR PRONOUNCED DEAD March 12, 1965 7:07 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Maryland A. STATE B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital 5. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore #34 2705 6. STREET ADDRESS (If rural, give location) 7700 Wilson Avenue

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married 8. DATE OF BIRTH Nov. 14, 1906 9. AGE (In years last birthday) 55 58 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Elmer Grimes 14. MOTHER'S MAIDEN NAME Lillian Krieger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2 16. SOCIAL SECURITY NO. 215-10-1126 17. INFORMANT Mrs. Annabelle Grimes 18. ADDRESS 7700 Wilson Ave.

18. CAUSE OF DEATH I 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Severe Arteriosclerosis of Coronary Arteries. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Emphysema and Chronic Pneumonitis.

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER DATE SIGNED 3/13/65 EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 3/17/65 23C. NAME OF CEMETERY or CREMATORY Taylorsville Cemetery 23D. LOCATION (City, town, or county) (State) Taylorsville, Md.

24A. DATE REC'D BY HEALTH DEPT. MAR 16 1965 24B. NAME OF REGISTRAR Robert E. Farley, M.D. 24C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. 14 Md. ADDRESS

VS 151-REV. 1/1/65 1 9 6 5 0 0 0 2 8 1 9

WALLEY STONE

PIC BOWMAN

Class 100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

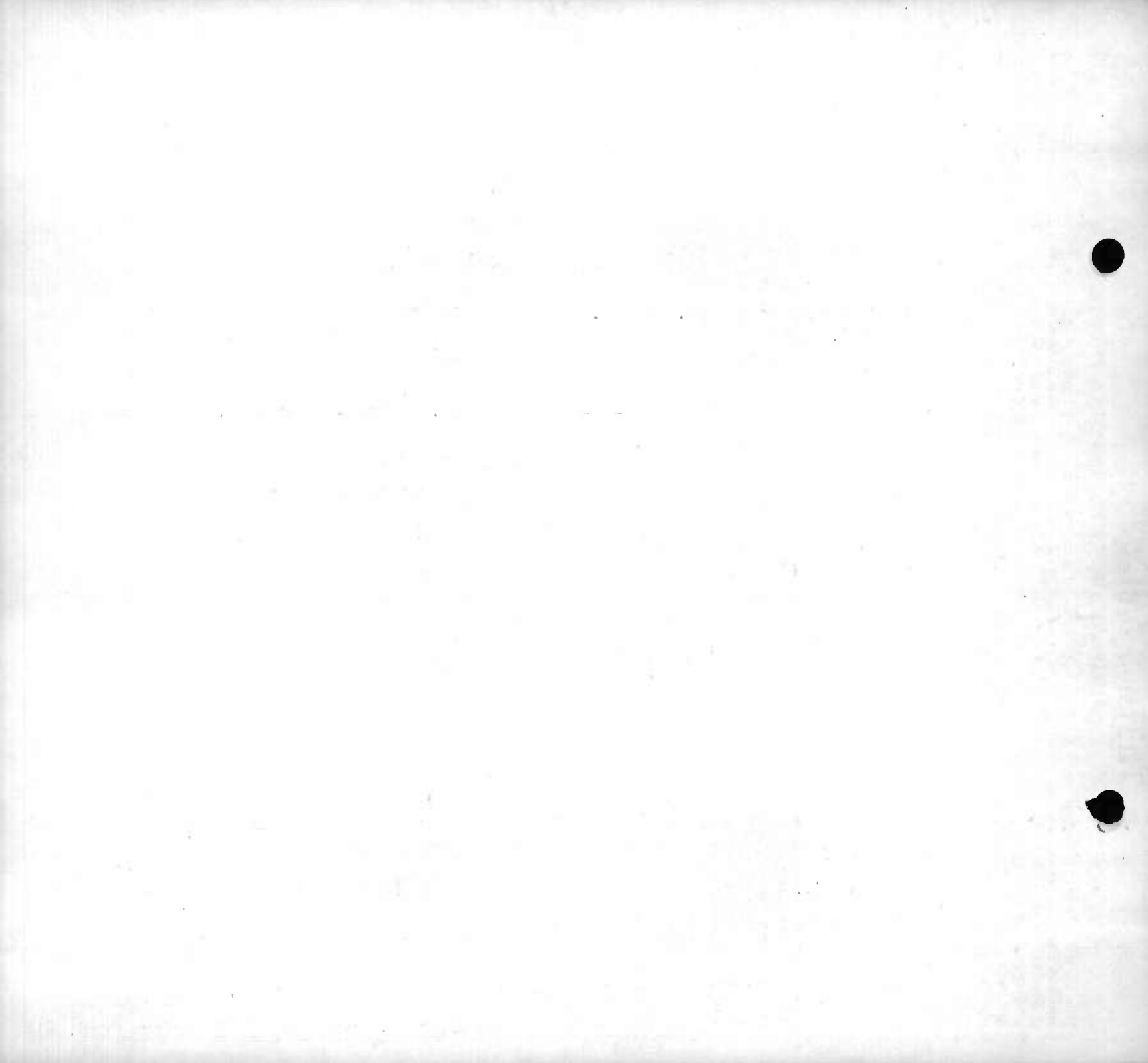
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 2815		<b>CERTIFICATE OF DEATH</b>		65 2815	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>IGNATIUS L. THALHEIMER</b>		2. DATE AND HOUR OF DEATH <b>3/13/65 9<sup>50</sup> P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1227 GLENHAVEN RD</b>			
5. SEX <b>19</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>19</b>	8. DATE OF BIRTH <b>2/5/01</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SOUTH COMD INC.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>JOHN THALHEIMER</b>		14. MOTHER'S MAIDEN NAME <b>ANGELENA HOOLIGAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-0799</b>		17. INFORMANT <b>(Wife) Marie E. Thalheimer</b> ADDRESS <b>same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>161X I</b>		CAUSE OF DEATH (A) <b>CA of LARYNX</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>3/6</b> 19 <b>65</b> to <b>3/13</b> 19 <b>65</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>3/13</b> 19 <b>65</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Edward A. Person</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>3/13/65</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. <b>Maryland General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/17/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Buck Inc 5305 Harford Road.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2816</u>	
BIRTH NO. <u>65 2816</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Ragnar THORSSSELL</u>		2. DATE AND HOUR OF DEATH <u>March 13 1965</u> <u>7:30 AM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>12-03</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>329 E. 29th Street</u>			
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED <u>Married</u>	8. DATE OF BIRTH <u>June 24, 1897</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Paymaster</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Am. Can Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Sweden</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>A. Johannes Thorssell</u>			
14. MOTHER'S MAIDEN NAME <u>Anna ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>216-03-6122</u>		17. INFORMANT <u>Mrs. Maria K. Thorssell</u>			
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Arteriosclerotic cardiovascular disease</u> DUE TO <u>myocardial infarction</u> (B) _____ DUE TO _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>same</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 6</u> 19 <u>65</u> to <u>March 13</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>March 13</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>L. G. Tilley</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>March 13, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>L. G. Tilley</u>		23D. ADDRESS <u>Maryland General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/17/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Stalley</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc</u>			
ADDRESS <u>5305 Harford Road. #14</u>					

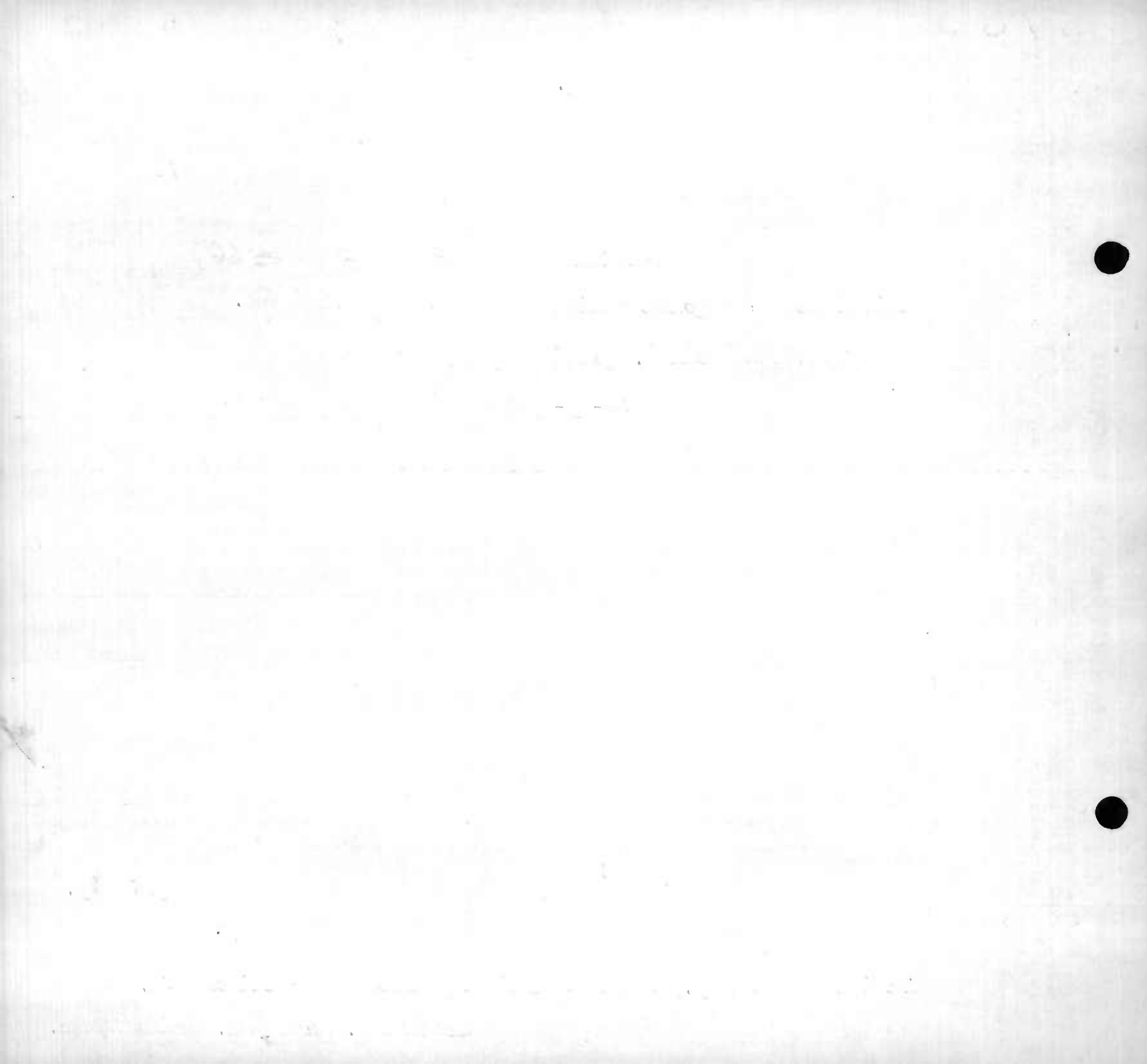




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

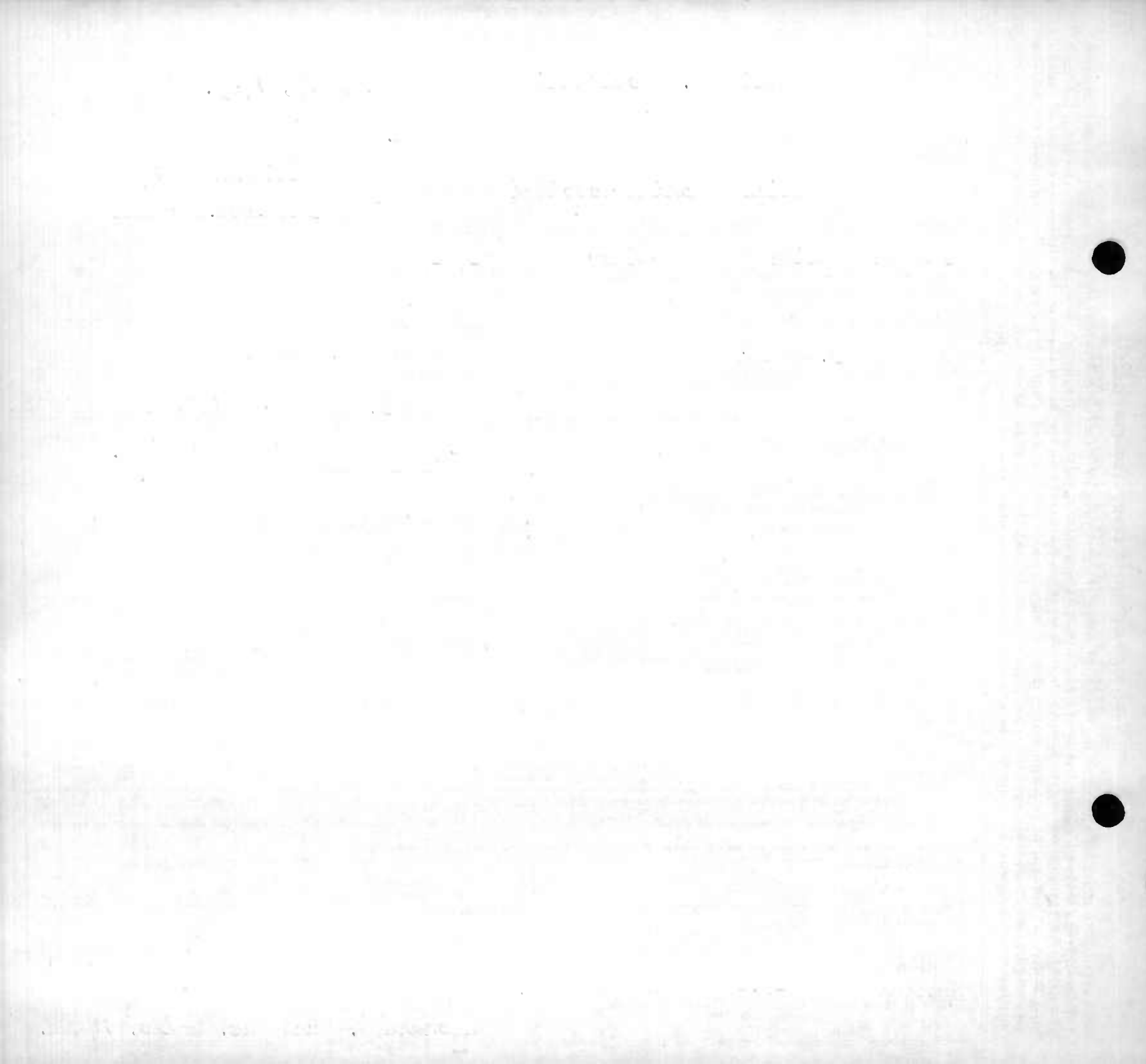
BIRTH NO. 65 2817				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2817	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Conniff, John E.</i>				2. DATE AND HOUR OF DEATH <i>March 12, 1965 11:30 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
<i>Franklin Square Hosp.</i>				<i>Maryland</i>		<i>9-03</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				<i>Baltimore #18</i>			
				D. STREET ADDRESS (If rural, give location)			
				<i>605 E. 35th St.</i>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
<i>M</i>	<i>W</i>	<i>Separated</i>	<i>3/18/1898</i>	<i>66</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Bricklayer</i>		<i>Construction</i>		<i>Baltimore Md.</i>		<i>U. S. A</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i><del>XXXXXXXXXX</del> John T. Conniff</i>				<i>Emma unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		<i>218-05-0762</i>		<i>Rosinawak Waldvogel</i>		<i>605 E. 30th St.</i>	
18. <i>434.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) <i>congestive heart failure</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<i>0</i>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3/11</i> 19 <i>65</i> to <i>March 12</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>March 12</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
<i>Kyo Rak Lee</i> M.D.				<i>3/12/65.</i>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
<i>Kyo Rak Lee</i> M.D.				<i>Franklin Square Hosp</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>3/16/65</i>		<i>Gardens of Faith Cemetery</i>		<i>Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<i>MAR 16 1965</i>		<i>Robert E. Staley</i>		<i>Leonard J. Ruck Inc.</i>		<i>Balto 14 Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

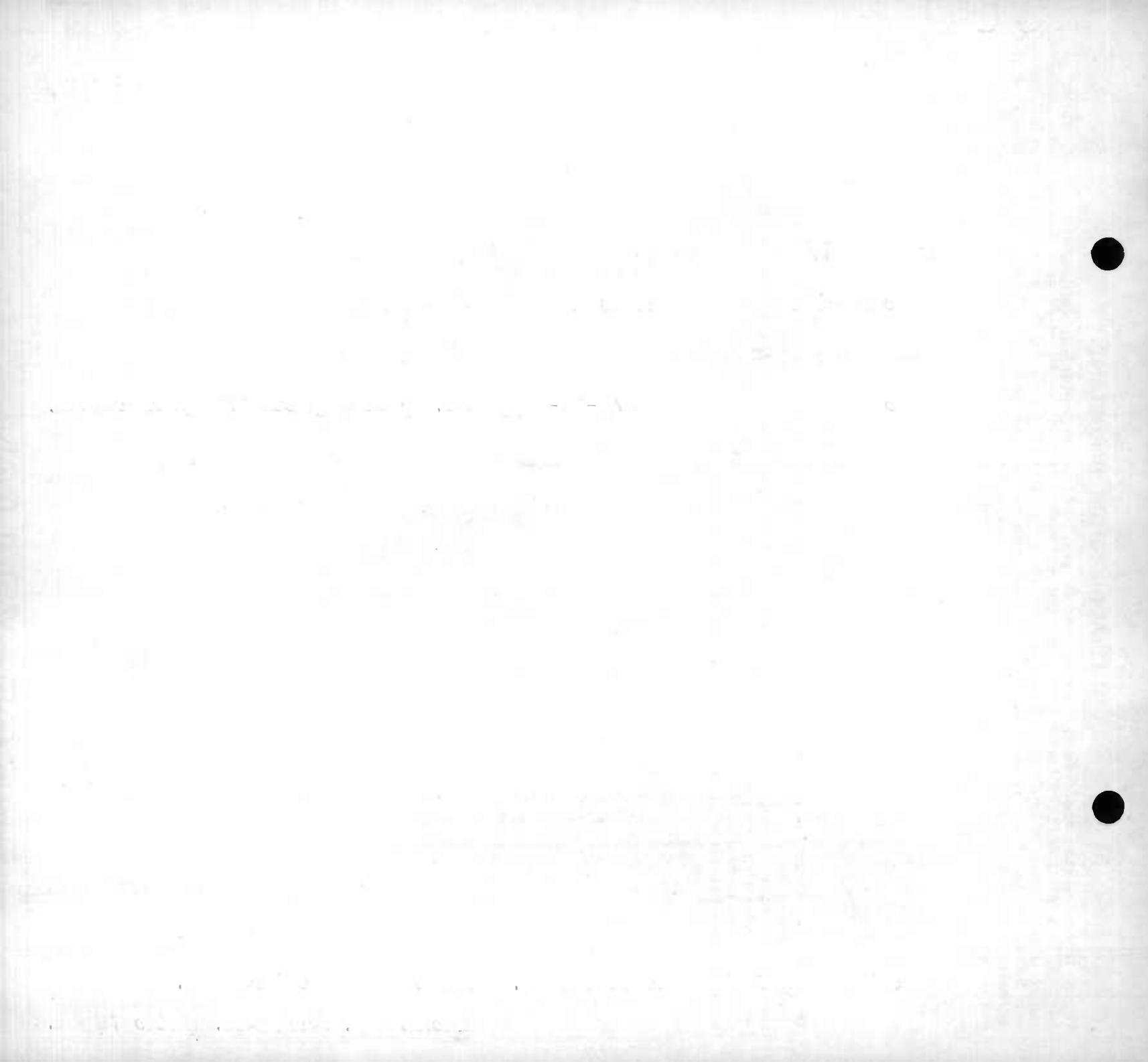
BIRTH NO. 65 2818		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2818	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Julia M. Bocchetti		2. DATE AND HOUR OF DEATH March 13, 1965.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY 27-05	
Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore # 14	
		D. STREET ADDRESS (If rural, give location)		3023 Fleetwood Avenue	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 7-23-1897	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William F. Dahle		14. MOTHER'S MAIDEN NAME Margaret A. Cooper		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT William F. Bocchetti 1211 Linkside Dr.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Hemorrhage Arterio-sclerotic Cerebro-vascular disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years 10 yrs. 5 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ① Diabetes mellitus ② Residual Hemiplegia			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 10 1949 to Mar. 13 1965, that (I) (we) last saw the deceased alive on March 1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George Sawyer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/15/65	
23C. PHYSICIAN'S NAME (Type) GEORGE SAWYER, M.D.		23D. ADDRESS 4808 Hayford Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial	24B. DATE 3-17-65	24C. NAME of CEMETERY or CREMATORY Moreland Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. 14 Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2819		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2819	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Jessie I. Bakstie</i>			2. DATE AND HOUR OF DEATH <i>March 13, 1965 1:40 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>26-01</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #6</i> D. STREET ADDRESS (If rural, give location) <i>5602 Todd Ave.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	B. DATE OF BIRTH <i>Nov. 20, 1890</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Charles Gousha</i>			14. MOTHER'S MAIDEN NAME <i>Dena Hertman</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-20-0673</i>	17. INFORMANT ADDRESS <i>Mrs. Evelyn Evert 212 Charmuth Rd.</i>		
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>Acute Myocardial Infarction</i> <i>Arteriosclerotic Cardiovascular Disease</i>			CAUSE OF DEATH  INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 13 1965</i> to <i>March 13 1965</i> , that (I) (we) last saw the deceased alive on <i>March 13 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="radio"/> (did) (did not) view the body after death.					
23A. SIGNATURE <i>L. G. Tilley</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>March 13, 1965</i>
23C. PHYSICIAN'S NAME (Type) <i>L. G. Tilley</i>			23D. ADDRESS <i>Maryland General Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3/16/65</i>	24C. NAME OF CEMETERY or CREMATORY <i>Moreland Mem. Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 16 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Stuber, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc. Balto 14 Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2820</u>	
BIRTH NO. <u>65 2820</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Katherine Tunney</u>		2. DATE AND HOUR OF DEATH <u>March 12, 1965</u>   <u>8:00 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>902</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>115 E. Melrose Ave.</u> <u>Long Green Nursing Home</u>		D. STREET ADDRESS (If rural, give location) <u>2915 Overland Ave.</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>single</u>	8. DATE OF BIRTH <u>Jan. 28, 1873</u>	9. AGE (In years last birthday) <u>92</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Schools</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Tunney</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Cashen</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Dr. Robert B. Tunney</u> ADDRESS <u>8106 Hartford Rd.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>450.01 + 170X</u>		CAUSE OF DEATH <u>Iliaic arterial thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <u>Generalized Arteriosclerosis</u>		(B) DUE TO <u>Indefinite</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Carcinoma breast (operated)</u>		<u>5 yrs.</u>	
<u>Arteriosclerotic Heart Disease</u>				<u>15 yrs</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>DEC 19 50</u> to <u>12 MAR 19 65</u> , that (I) (we) last saw the deceased alive on <u>12 Mar</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>John B. DeHoff</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>13 Mar 65</u>	
23C. PHYSICIAN'S NAME (Type) <u>John B. DeHoff</u>		23D. ADDRESS M.D. <u>1701 Meridene Drive</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>3-15-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>	



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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

65 2821

BIRTH NO. 65 2821

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

McCloud, Noonie Annie

2. DATE AND HOUR OF DEATH

March 12, 1965 12:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore 21218

D. STREET ADDRESS (If rural, give location)

2728 Tivoly Ave.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)  
Widowed

8. DATE OF BIRTH

June 10, 1906

9. AGE (In years last birthday)  
89 58

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Davis, West Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Wilfong

14. MOTHER'S MAIDEN NAME

Annie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Franklin J. McCloud

ADDRESS

same

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Recent anterior myocardial infarct

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus; old infarct of left temporal lobe of brain

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

White At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 4, 19 65 to March 12, 19 65, that (I) (we) last saw the deceased alive on March 12, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William B. VandeGrift

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

March 12, 1965

23C. PHYSICIAN'S NAME (Type)

William B. VandeGrift,

M.D.

23D. ADDRESS

1400 N. Caroline St., Baltimore, Md. 21213

24A. BURIAL CREMATION, REMOVAL (Specify)

burial

24B. DATE

3-16-65

24C. NAME of CEMETERY or CREMATORY

Westernport Cemetery

24D. LOCATION (City, town, or county) (State)

Westernport, Md.

25A. DATE REC'D BY HEALTH DEPT.

MAR 16 1965

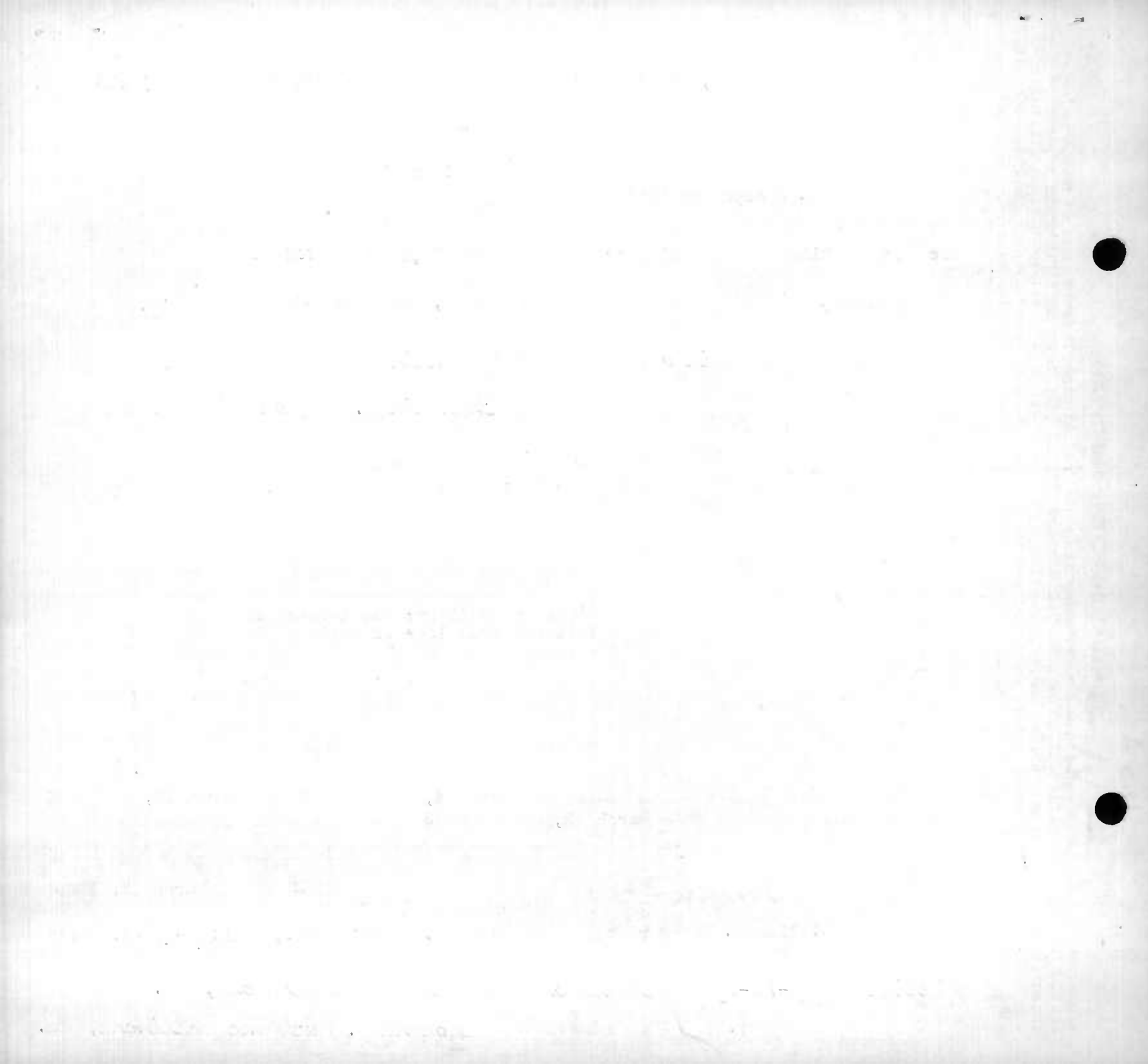
25B. NAME OF REGISTRAR

Robert E. Fisher

25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc Baltimore, Md.

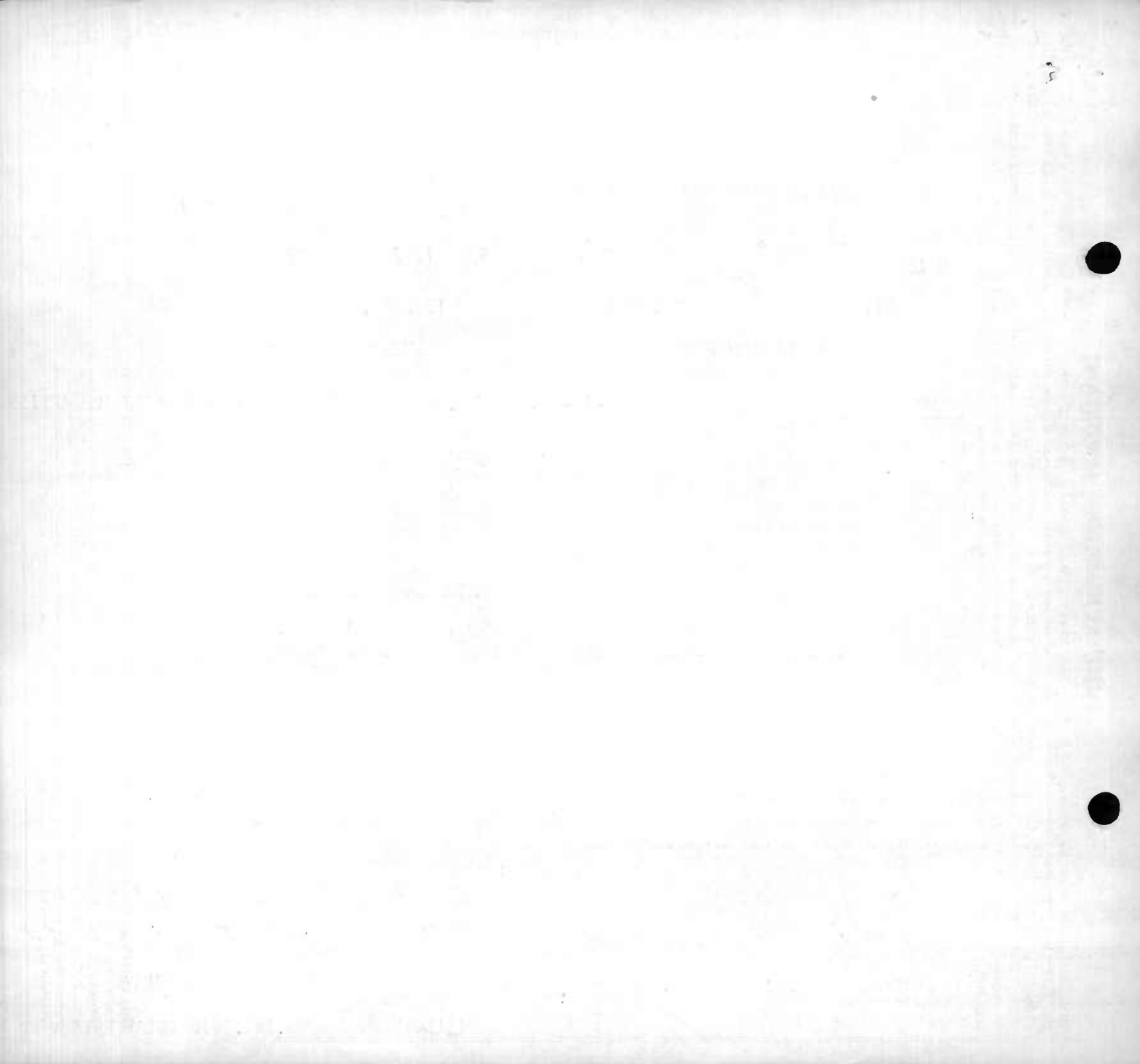
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2822				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2822	
M.E. CASE NO. 65 2822				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ISRAEL WINEBERG				2. DATE AND HOUR OF DEATH MAR 12 1965 9:15 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3909 EDGEWOOD ROAD APT 135				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3909 EDGEWOOD ROAD APT 135			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9/24/1887	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY SHOE SALESMAN		11. BIRTHPLACE (State or foreign country) TORONTO, CANADA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRIS WINEBERG				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 356-14-2486		17. INFORMANT MRS. SOPHIA WINEBERG 3909 EDGEWOOD AVE APT 135			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH 1 Hour.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 15 19 47 to MAR 12 1965, that (I) (we) last saw the deceased alive on MAR 12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Albert J. Himelfarb M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 3/12/65			
23C. PHYSICIAN'S NAME (Type) ALBERT J. HIMELFARB				23D. ADDRESS 3501 ST. PAUL ST BALTO. Md #18			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 3/14/65		24C. NAME OF CEMETERY or CREMATORY BETH EL		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965		25B. NAME OF REGISTRAR R. J. E. F. F. F.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Baltimore City Health Department		Registered No. 65 2823	
BIRTH NO. 65 2823		M.E. CASE NO. 65 2823		1. NAME OF DECEASED (Type or Print) ISODORE MAZUR		2. DATE AND HOUR OF DEATH 3/12/65 2:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 2803	
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 1885	
9. AGE (In years lost birthday) 80		10. CITIZEN OF WHAT COUNTRY? USA		11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. SARAH MAZUR			
				ADDRESS 4401 FOREST PARK AVE			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) CONGESTIVE HEART FAILURE (B) ACUTE MYOCARDIAL INFARCTION (C) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (D) UREMIA MOD. SEVERE			
				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-21-1965 to 3-12-1965, that (I) (we) last saw the deceased alive on 3-12-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Renato R. Espina				23B. DATE SIGNED 3/12/65		23C. PHYSICIAN'S NAME (Type) RENATO R. ESPINA	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/14/65		24C. NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SQL LEVINSON & BROS. INC. 6010 REISTERSTOWN			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

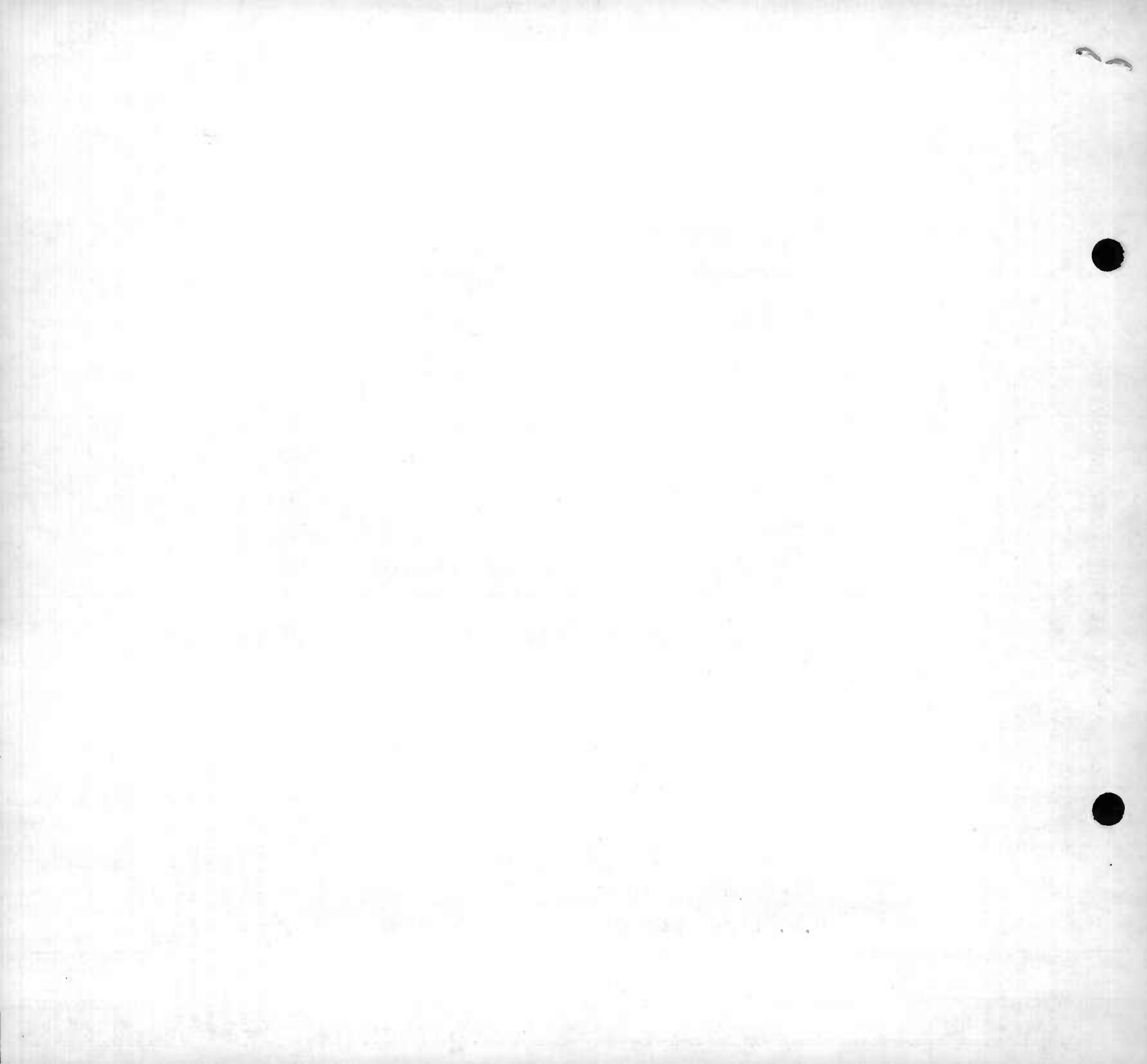
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2824</u>	
BIRTH NO. <u>65 2824</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>533</u>		1. NAME OF DECEASED (Type or Print) <u>Samuel Dinowitz</u>		2. DATE AND HOUR OF DEATH <u>3/10/65</u> <u>6:45</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <u>SINAI HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>15-13</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2630 QUANTICO AVE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>MARRIED</u> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>4/21/1896</u>	9. AGE (In years last birth) <u>68</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JACOB DINOWITZ</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-26-8140</u>		17. INFORMANT <u>MRS. EVA DINOWITZ</u> ADDRESS <u>2630 QUANTICO AVE</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>610X I</u> <u>Prostatism with uremia</u> <u>2° to Post Renal Obstruction</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>arteriosclerotic cardiovascular disease, congestive heart failure, severe anemia</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> 19 <u>65</u> to <u>3/10</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/10/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>F SAINTZ</u>		23D. ADDRESS <u>Sinai Hosp 17 E. 17 St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3/11/65</u>		24C. NAME of CEMETERY or CREMATORY <u>OHEL YAKOV</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1965</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS. INC.</u> ADDRESS <u>6010 REISTERSTOWN RD</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

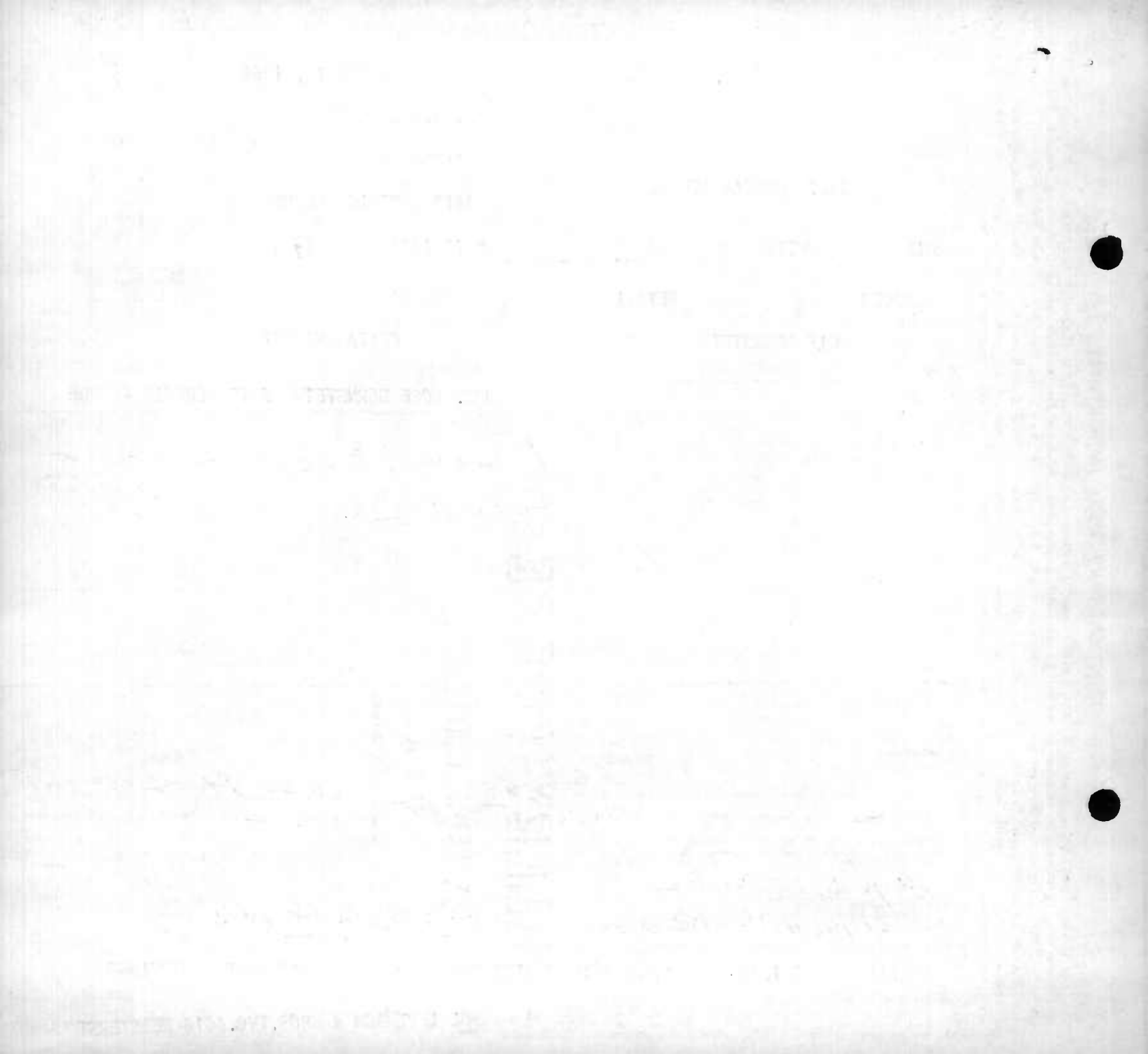
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2825	
BIRTH NO. 65 2825		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lillian Naden		2. DATE AND HOUR OF DEATH 3/14/65 11:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital		A. STATE MD. B. COUNTY 27-20		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15 Ford LEIGH	
D. STREET ADDRESS (If rural, give location) 4000 Fordley Rd.		5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed		8. DATE OF BIRTH 2/27/95 9. AGE (In years, lost birth day) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME 7		14. MOTHER'S MAIDEN NAME JENNIE T	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital chart ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Cerebrovascular Accident		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES		(B) DUE TO Hemorrhagic Shock		3 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Ulcerative Colitis		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arteriosclerosis		19A. DATE OF OPERATION 2 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/8 1965 to 3/14 1965, that (I) (we) last saw the deceased alive on 3/14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D.V. Lindenstruth		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/14/65	
23C. PHYSICIAN'S NAME (Type) D.V. Lindenstruth		23D. ADDRESS University Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/65		24C. NAME OF CEMETERY or CREMATORY Sharian Zion	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. FUNERAL DIRECTOR	



# FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				Certificate of Death		Registered No. <u>65 2826</u>	
BIRTH NO. <u>65 2826</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JACOB H. BERNSTEIN</u>		2. DATE AND HOUR OF DEATH <u>MARCH 15, 1965</u> <u>11 P</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <u>3817 NORFOLK AVENUE</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>15-09</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>3817 NORFOLK AVENUE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	B. DATE OF BIRTH <u>2/15/1898</u>	9. AGE (In years lost birthday) <u>67</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WOLF BERNSTEIN</u>				14. MOTHER'S MAIDEN NAME <u>CELIA SHEPPATIN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MRS. ROSE BERNSTEIN 3817 NORFOLK AVENUE</u>			
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Pulmonary Embolism</u> DUE TO (B) <u>Congestive heart failure</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>Several years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19 62 to March 15 19 65</u> , that (I) <u>last</u> saw the deceased alive on <u>March 15 19 65</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Seymour H. Rubin</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3/15/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Seymour H. Rubin</u>				23D. ADDRESS <u>5415 Park Heights Ave. Baltimore - 15</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3/16/65</u>	24C. NAME OF CEMETERY or CREMATORY <u>ANSHE EMUNAH AITZ CHAIM</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1965</u>		25B. NAME OF REGISTRAR <u>R. B. E. Starkey</u>		25C. FUNERAL DIRECTOR ADDRESS <u>901 LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</u>			



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SAMUEL

ROSENFELD

2. DATE AND HOUR PRONOUNCED DEAD

March 14, 1965

11:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

918 N. Calvert Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

NEWS STAND

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

MORRIS ROSENFELD

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

218-16-1689

17. INFORMANT

ADDRESS

MRS. ESTELLE KNELL 8105 GRAY HAVEN RD

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic  
DUE TO cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Peter W. Rieckert, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

3-15-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

3/16/65

23C. NAME of CEMETERY or CREMATORY

OHEB SHALOM

23D. LOCATION

(City, town, or county)

BALTIMORE

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

MAR 16 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD

ADDRESS

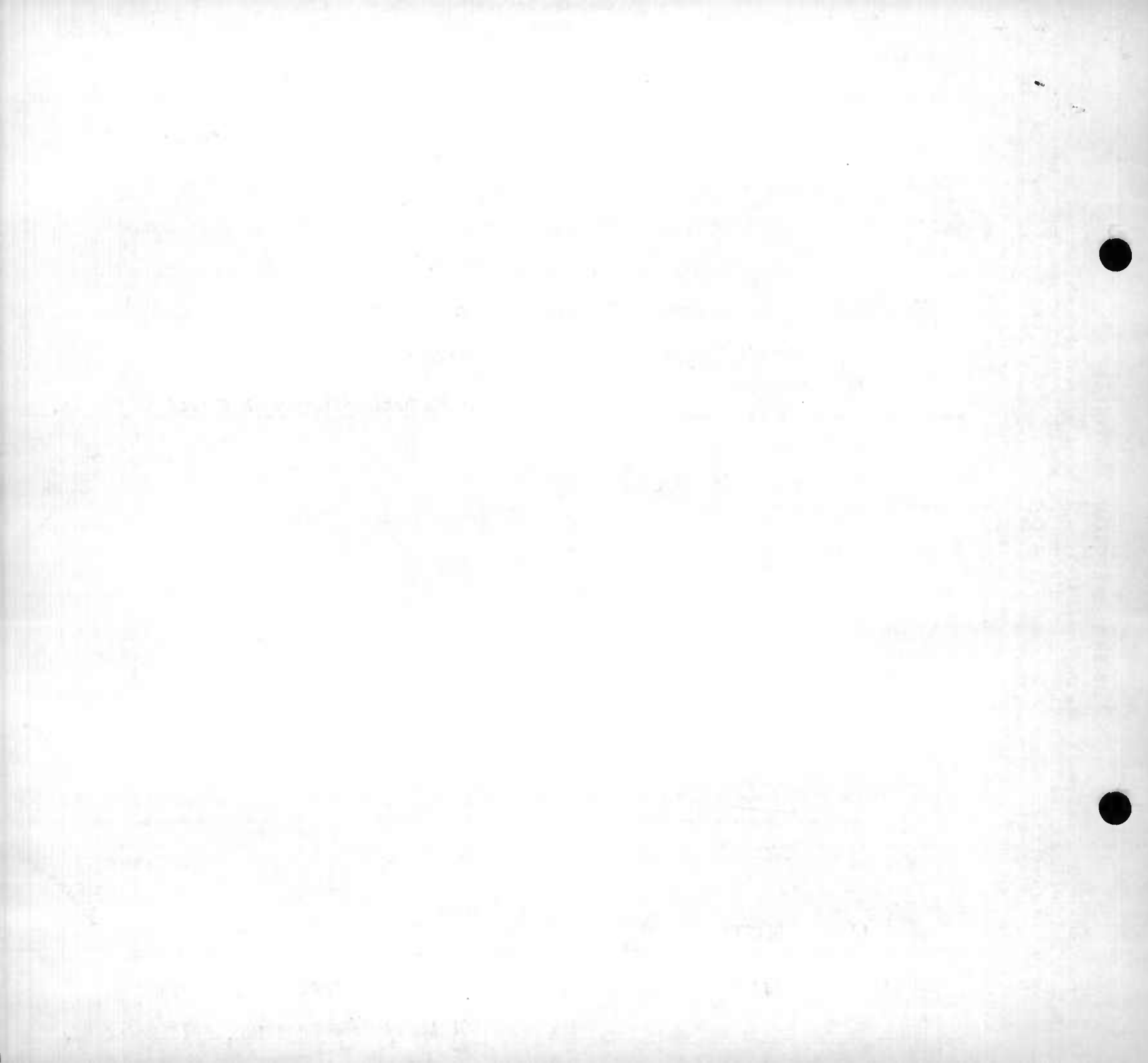


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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>65 2828</b>		<b>CERTIFICATE OF DEATH</b>		65 2828	
M.E. CASE NO.			DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Kupper, Benjamin</b>			3-13-65 6:35 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Sinai Hospital of Baltimore</b>			A. STATE <b>Maryland</b> B. COUNTY <b>27-20</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>5806 Western Run Dr.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug 3, 1896</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wholesale</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Candy &amp; Tobacco</b>		11. BIRTHPLACE (State or foreign country) <b>New York City</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Morris Kupper</b>		
14. MOTHER'S MAIDEN NAME <b>Esther Schwartz</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mrs Katherine Kupper</b>		
			ADDRESS <b>5806 Western Run Dr.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>420.1 I</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>			CAUSE OF DEATH <b>Anteriosclerotic Cardiovascular Disease</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-13-65</b> to <b>3-13-65</b> , that (I) (we) lost saw the deceased alive on <b>3-13-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Larry Becker, M.D.</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-13-65</b>
23C. PHYSICIAN'S NAME (Type) <b>LARRY BECKER</b>			23D. ADDRESS <b>4924 Lamin Ave. Balto. 15, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/14/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Shaarei Tfiloh Cong.</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>			
25A. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25B. FUNERAL DIRECTOR <b>SQL LEVINSON &amp; BROS INC.</b>			
25C. ADDRESS <b>6010 Reist Rd.</b>					



P. 600

65 2829

BALTIMORE CITY HEALTH DEPARTMENT

65 2829

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARGIE (Margorie) PERRY

2. DATE AND HOUR PRONOUNCED DEAD

March 10, 1965

4:20 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1416 E. Lombard Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1414 E. Lombard Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan 6 - 1912

9. AGE (In years  
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert E. Kausie

14. MOTHER'S MAIDEN NAME

Caroline Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Marlene Perry

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Lobar Pneumonia.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK

NOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/11/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3-15-1965

23C. NAME OF CEMETERY or CREMATORY

MT. Calvary Cmt

23D. LOCATION (City, town, or county) (State)

Brooklyn, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 16 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Choy O. Wilson 1000 Brantley

ADDRESS

Class 1st

Oct

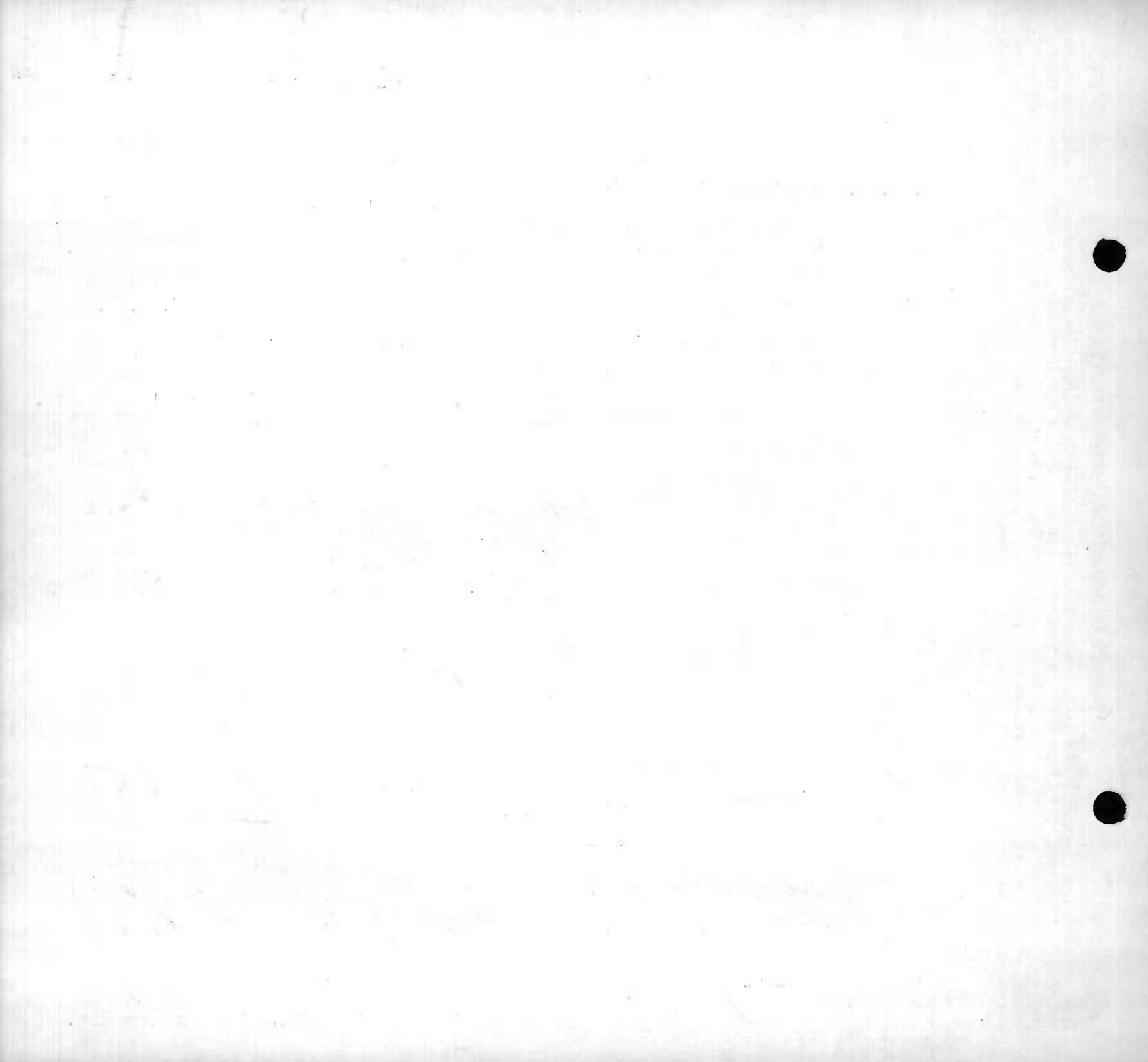
Class 2nd

Class 3rd

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2830		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2830	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		JAMES F. DABROWSKI		2. DATE AND HOUR OF DEATH March 14, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		D. O. A. Baltimore City Hospital		Maryland 2609	
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH April 18, 1900		9. AGE (In years last birthday) 64		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Anthony Dabrowski		14. MOTHER'S MAIDEN NAME Constance Strzegowski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Margaret Dabrowski 3500 O'Donnell St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Acute myocardial infarction (B) DUE TO Atherosclerotic heart disease with left coronary myocardial infarction (C) Chronic alcoholism with hepatic cirrhosis		INTERVAL BETWEEN ONSET AND DEATH 30 min. 8 yrs. 8 yrs. or more	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 25 Jul 1957 19 to 19 Feb 65 19 that (I) (we) last saw the deceased alive on 19 Feb 65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Bronushas, M.D.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 14 Mar 65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 3037 O' Donnell St Baln 24 N D			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-18-1965		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965			
25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.			

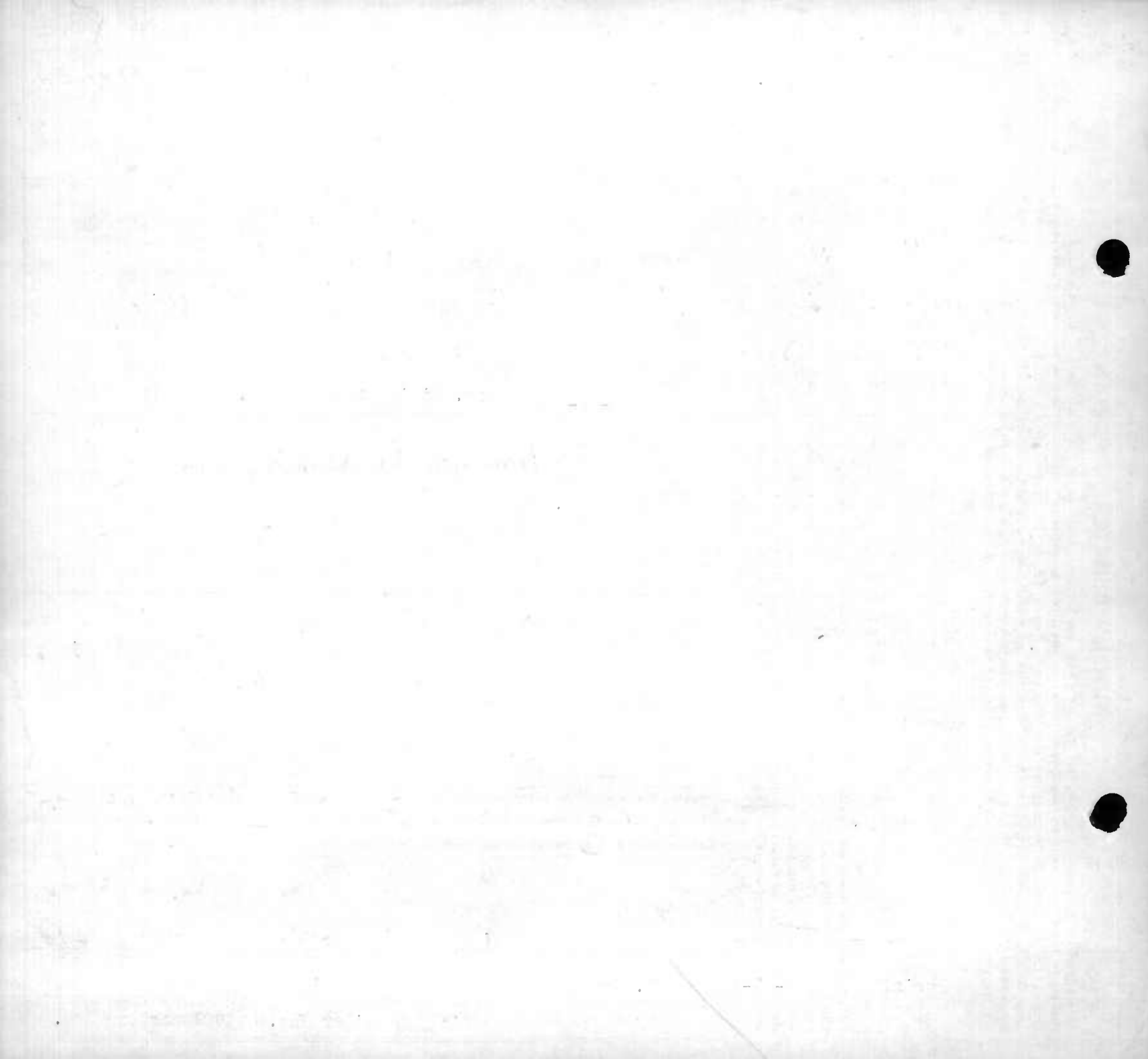




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2831</u>	
BIRTH NO. <u>65 2831</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>65 2831</u>		1. NAME OF DECEASED (Type or Print) <u>John H. Darr</u>		2. DATE AND HOUR OF DEATH <u>March 13, 1965</u> <u>9:45 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>26-05</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>614 S. Rappolla St.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 18, 1908</u>	9. AGE (In years lost birthday) <u>57</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Oakie Darr</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Myers</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-01-2245</u>	17. INFORMANT <u>Mrs. Marie Darr</u>		ADDRESS <u>614 S. Rappolla Street</u>
18. <u>204.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Monocytic Leukemia, chronic</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>February 26, 1965</u> to <u>March 13, 1965</u> , that (I) (we) lost saw the deceased alive on <u>March 13, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>L. G. Tilley</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>March 13, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>L. G. Tilley</u>		23D. ADDRESS <u>Maryland General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>3-17-1965</u>	24C. NAME OF CEMETERY or CREMATORY <u>Mt. Carmel</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Lilly &amp; Zeiler Inc.</u>	
				ADDRESS <u>1901 Eastern Ave.</u>	



W 330

65 2832

BALTIMORE CITY HEALTH DEPARTMENT

65 2832

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ALFRED NORMAN WHITTED

2. DATE AND HOUR PRONOUNCED DEAD

March 13, 1965 7:59 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

253 Robert Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

2-25-1925

9. AGE (In years  
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Foreman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Durham, N. C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

London Whitted

14. MOTHER'S MAIDEN NAME

Mary Snead

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

245-26-8994

17. INFORMANT

ADDRESS

Mrs. Florence Whitted 253 Robert St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Myocardial Infarction  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Thrombosis of Right Coronary Artery  
DUE TO

(C) Arteriosclerotic Heart Disease.

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/14/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3-20-65

23C. NAME OF CEMETERY or CREMATORY

Beachwood Cemetery

23D. LOCATION

(City, town, or county)

Durham, N.C.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 16 1965

24B. NAME OF REGISTRAR

Robert E. Taylor M.D.

24C. FUNERAL DIRECTOR

Horton &amp; Dyett

ADDRESS

916 Penna. Ave.  
Baltimore, Md. 21201

WALLEN P. J. G. I.

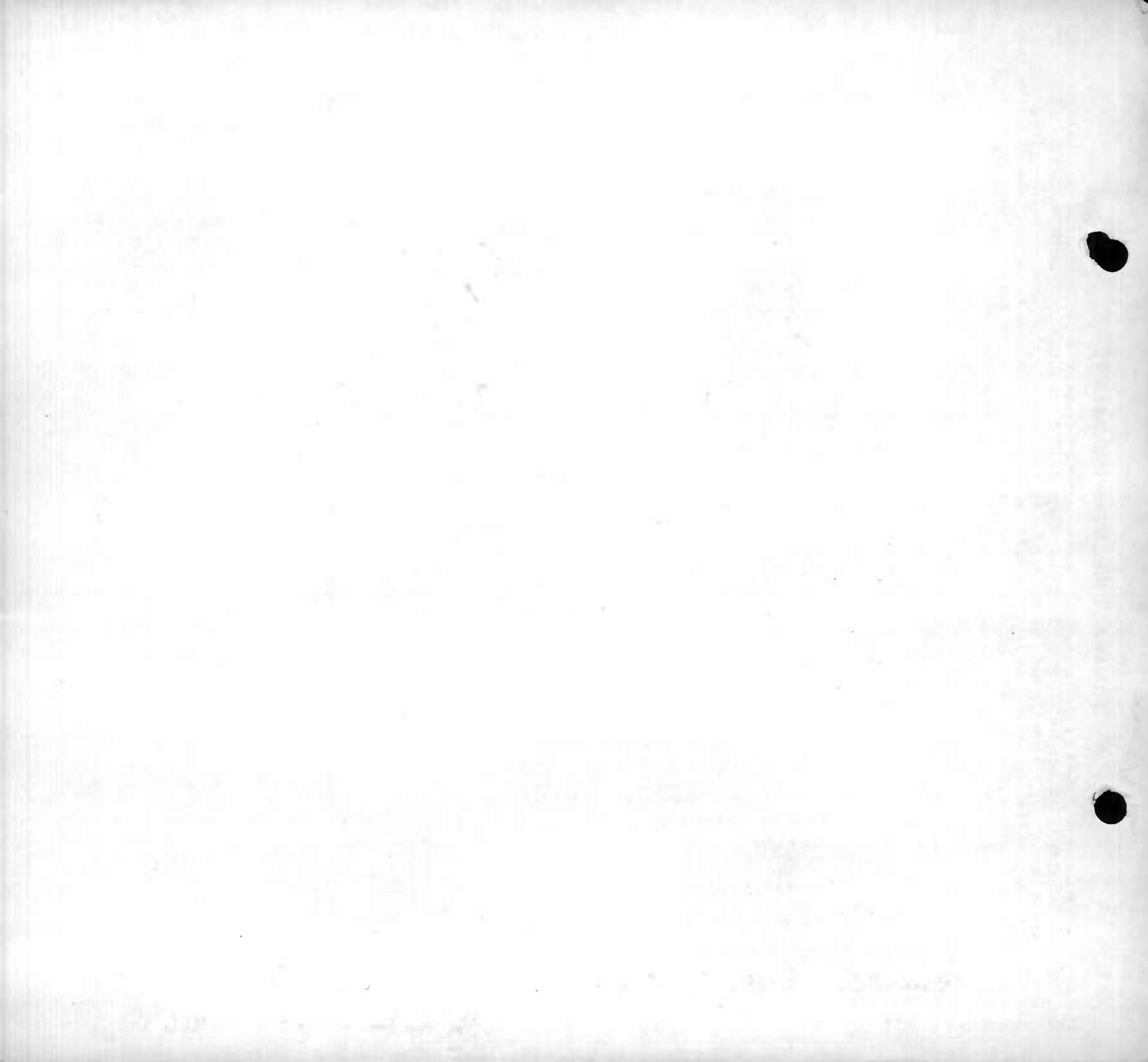
1945

Class 1/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2833</b>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b>		Registered No. <b>65 2833</b>	
M.E. CASE NO.		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <i>Lafayette Tracy</i>		2. DATE AND HOUR OF DEATH <i>3-14-65 17:30 P.M.</i>			
3. PLACE OF DEATH <i>IN BALTIMORE, MARYLAND</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lincoln Memorial Nursing Home</i> <i>277 Carey St Bldg 212-23</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>17-03</i>			
5. SEX <i>Male</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>2-1-1888</i>	9. AGE (In years last birthday) <i>77</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Elevator operator</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Unk.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>Unk.</i>		14. MOTHER'S MAIDEN NAME <i>Unk.</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-073145</i>		17. INFORMANT ADDRESS <i>C. Stein 3632 Fords Lane</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Cardio Vascular Disease</i> (B) DUE TO <i>2</i> (C)		INTERVAL BETWEEN ONSET AND DEATH	
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. R. Johnson</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3/14-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>W. R. Johnson</i>		23D. ADDRESS <i>403 N. Charles St</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-15-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT. CALVARY</i>	
24D. LOCATION (City, town, or county) <i>A.A. Co.</i>		24E. STATE <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 16 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>916 Penina Ave</i>	

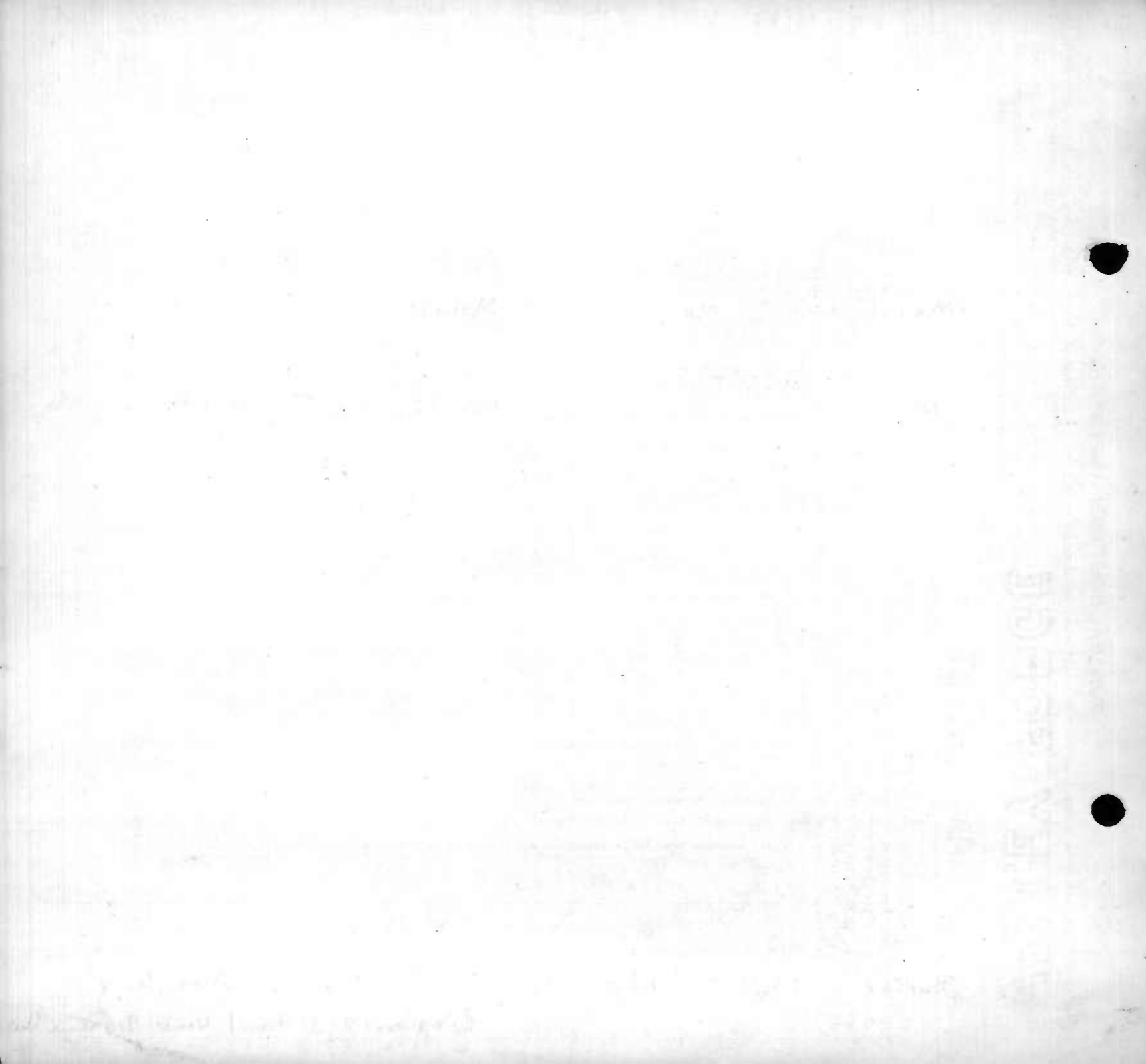


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2834		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2834	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) EDWARD MATTHEWS		2. DATE AND HOUR OF DEATH 3-11-65 9 35/P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND		A. STATE B. COUNTY Maryland 18-02			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1004 BENNETT PLACE			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH April-23-1900	9. AGE (In years last birthday) 64	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY MA	11. BIRTHPLACE (State or foreign country) Mobile, Ala.		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Edna Scott		ADDRESS 1004 BENNETT PLACE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ELECTROLYTE Imbalance Intestinal obstruction Tumor of the sigmoid		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION March 11/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Intestinal obstruction		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 10 1965 to March 11 1965, that (I) (we) lost saw the deceased alive on March 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Adolfo G. de Perio		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED March 12/65	
23C. PHYSICIAN'S NAME (Type) Adolfo G. de Perio		M.D. 23D. ADDRESS LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/65		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park Cem.	
24D. LOCATION (City, town, or county) (State) Arbutus Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR The Mortuary & Dyett Family Home		ADDRESS 916 Penna Ave			

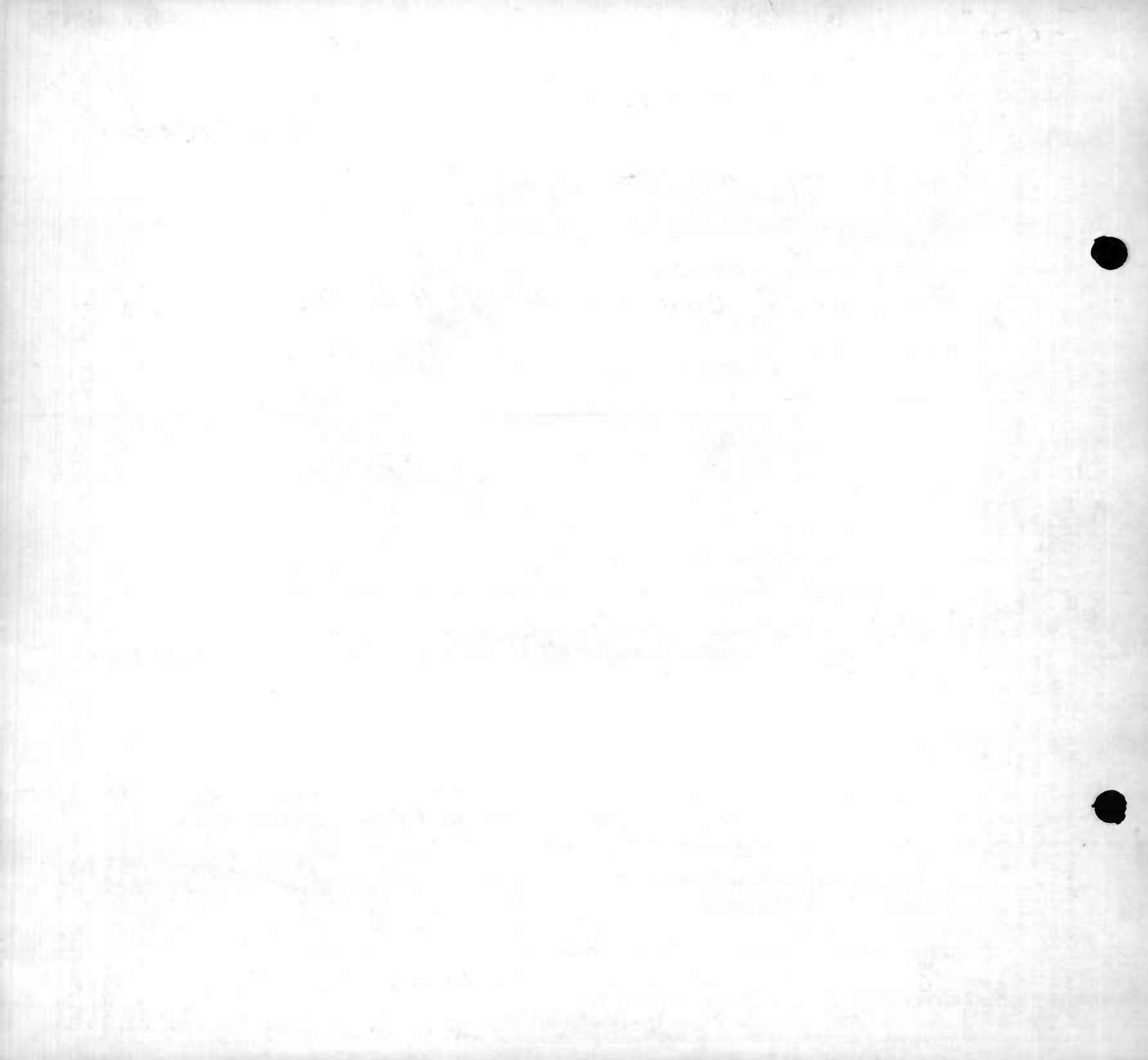




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
665 2835					665 2835					
BIRTH NO.					Registered No.					
M.E. CASE NO.					1. NAME OF DECEASED					
					2. DATE AND HOUR OF DEATH					
(Type or Print) STALLINGS, FRANK B.					3/13/65 7 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY					
UNIVERSITY HOSPITAL					Md. Anne Arundel					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
					Annapolis 52-10					
					D. STREET ADDRESS (If rural, give location)					
					1711 Forest Dr.					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		
M		W				10/17/11		53		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Tractor operator			Civil Service			D. D. Co Md.			U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Gordon Stallings					Alice Bramble					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
							Wife - Cordelia Stallings - same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) Brain Tumor					3 wks.
ANTECEDENT CAUSES					(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) DUE TO					
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
3/11/65		Craniotomy			Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
(Month) (Day) (Year) (Hour)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 2, 23, 19 65 to 3, 13, 19 65, that (I) (we) last saw the deceased alive on 3, 13, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE					23B. DATE SIGNED					
Thavatchai Fuangvudhiran M.D.					3.13.65					
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS					
THAVATCHAI FUANGVUDHIRAN M.D.					University Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)			
Burial		3/17-1965		Glen Haven Memorial			Glen Burnie Md.			
25A. DATE REC'D BY HEALTH DEPT			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS				
MAR 16 1965			Robert E. Staley, M.D.			John M. Taylor, Annapolis, Md.				



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2836		CERTIFICATE OF DEATH		Registered No. 65 2836	
1. NAME OF DECEASED (Type or Print) <b>Joseph Mellinger Bassett</b>				2. DATE AND HOUR OF DEATH <b>March 13, 1965</b> <b>6:30P.</b> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3803 Callaway Avenue Baltimore, Maryland 21215</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-11</b>					
5. SEX <b>Male</b>				6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>		8. DATE OF BIRTH <b>July 18, 1892</b>	
9. AGE (In years last birthday) <b>72</b>				10. AGE (In years last birthday) <b>72</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Merchant</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>George R. Bassett</b>				14. MOTHER'S MAIDEN NAME <b>Mary Eleanor Stevens</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-44-2031</b>		17. INFORMANT <b>Rev. J. Kemp Tunis</b>		ADDRESS <b>3803 Callaway Ave. Md. 21215</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion</b>				19. CAUSE OF DEATH (A) DUE TO <b>disease</b> <b>Arteriosclerotic cardiovascular</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>10 years</b>			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic generalized rheumatoid arthritis</b>				21. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Chronic generalized rheumatoid arthritis</b>		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>20 years</b>			
23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>0 *****</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>*****</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>*****</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner) <b>*****</b>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>*****</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>*****</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>*****</b>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>*****</b>			
22. I certify that (1) <del>this hospital</del> attended the deceased from <b>1950</b> to <b>March 13, 1965</b> , that (1) <del>was</del> last saw the deceased alive on <b>March 13, 1965</b> and that in (my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above. (1) <del>was</del> (did) <del>not</del> view the body after death.									
23A. SIGNATURE <i>Millard T. Traband, Jr.</i>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>March 15, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Millard T. Traband, Jr.</b>						23D. ADDRESS <b>5101 Gwynn Oak Ave. Baltimore, Md. 21207</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/17/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>		25B. NAME OF REGISTRAR <i>R. E. Staley</i>		25C. FUNERAL DIRECTOR <i>Wm. J. Fickner &amp; Son</i>		ADDRESS <b>Baltimore, Md. 17 North Pa. Ave.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2837		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2837	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print)		ZETTA TROLLINGER SANDERS		2. DATE AND HOUR OF DEATH Mar. 15, 1965 2 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Va. B. COUNTY K-43		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Virginia Beach	
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital Wyman Pk. Drive & 31st St.		D. STREET ADDRESS (If rural, give location) 409 Lord North Road			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Div.	8. DATE OF BIRTH 12/23/32	9. AGE (In years last birthday) 32	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Calif.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward D. Trollinger		14. MOTHER'S MAIDEN NAME M. Grace Mitchie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 228-36-9099		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 201X I DUE TO Bronchopneumonia		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Hodgkins disease		12 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 25 19 65 to Mar. 15 19 65, that (I) (we) last saw the deceased alive on Mar. 15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Aaron Lupovitch, Surgeon (R)		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/15/65	
23C. PHYSICIAN'S NAME (Type) Aaron Lupovitch, Surgeon (R)		23D. ADDRESS M.D. US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 3/16/1965		24C. NAME OF CEMETERY or CREMATORY Forest Lawn Cemetery	
24D. LOCATION Norfolk, Virginia		24E. FUNERAL DIRECTOR Wm. J. Johnson & Sons		24F. ADDRESS Baltimore, Md. 17 North & P. aves.	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965		25B. NAME OF REGISTRAR Robert E. Staley, M.D.		25C. FUNERAL DIRECTOR Wm. J. Johnson & Sons	

1947-1948

1949-1950

1951-1952

1953-1954

1955-1956

1957-1958

1959-1960

1961-1962

1963-1964

1965-1966

1967-1968

1969-1970

1971-1972



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2838		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2838	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CAVE, THELMA R.		2. DATE AND HOUR OF DEATH 3-16-65 2:05 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY 2-22			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 31			
		D. STREET ADDRESS (If rural, give location) 106 S. REGISTER ST 31			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1-22-10	9. AGE (In years last birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Va	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME HENRY CLAY TROUP		14. MOTHER'S MAIDEN NAME BERTHA INMINGER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 232-26-4596		17. INFORMANT Roy F. Cave 106 S. Register St	
18. 560.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) POST OPERATIVE DUE TO ATELECTASIS - LOWER LOBES - DAY (B) PNEUMONIA DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-13 1965 to 3-16 1965, that (I) (we) last saw the deceased alive on 3-16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ephraim Barzaga M.D.				23B. DATE SIGNED 3-18-65	
23C. PHYSICIAN'S NAME (Type) Ephraim B. Barzaga M.D.		23D. ADDRESS CHURCH HOME & HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-18-65		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Co. Md		25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965			
25B. NAME OF REGISTRAR P. E. G. 3-18-65		25C. FUNERAL DIRECTOR 1800 E. Lombard St.			

3/24/65 - Date of Operation - 3/16/65

Condition for which operation

was performed - 1. Incarcerated incisional ventral

hernia

2. Tracheostomy

See Letter from Church Home & Hosp. Filed in Bur.  
of Biostatistics  
American Slig. p.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

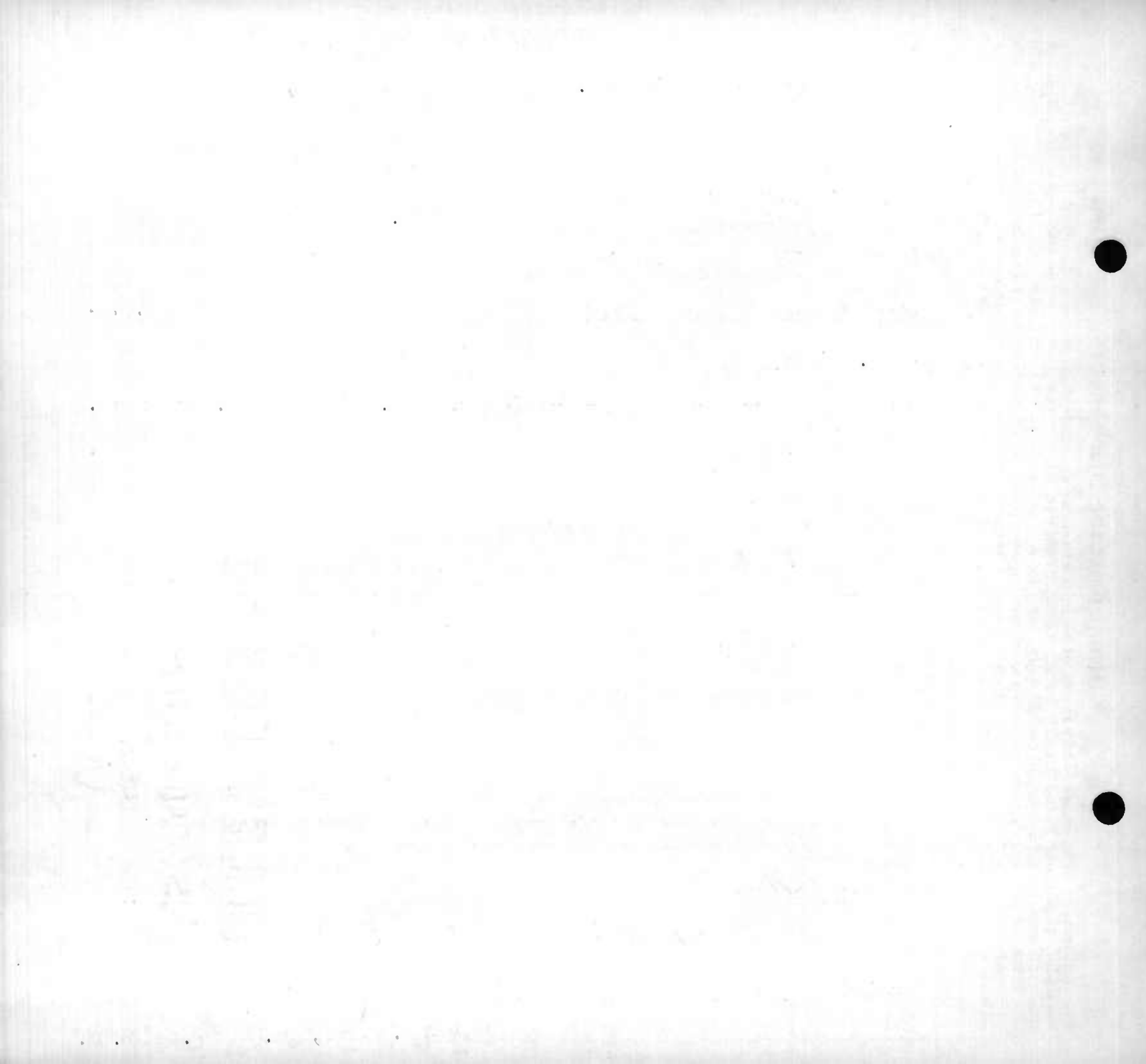
BIRTH NO. 65 2839		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2839	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) FRISK, ALGOT		
2. DATE AND HOUR OF DEATH 3-13-65 7:00 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 109 S. Broadway, Balto. 31, Md.			A. STATE Maryland B. COUNTY 2-02		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 31			D. STREET ADDRESS (If rural, give location) 109 S. Broadway		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-17-1896	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10B. KIND OF BUSINESS OR INDUSTRY Ship Supply		11. BIRTHPLACE (State or foreign country) Sweden	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Holcon Tranberg 1008 Glen Villa Drive	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			(A) Congestive Heart Failure few years		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Myocardial Infarction years		
			(C) Arterio-sclerotic Cardiovascular disease 1 year		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 11-6-59 19 to 3-2-65 19 and that (I) (we) last saw the deceased alive on 3-2-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Cesar R. Bariso, M.D.		23B. DATE SIGNED 3-13-65		23C. PHYSICIAN'S NAME (Type) CESAR R. BARISO, M.D.	
23D. ADDRESS Church Home & Hospital Balto. 31, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/65	
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965	
25B. NAME OF REGISTRAR R. E. Farber		25C. FUNERAL DIRECTOR John A. Monan, Inc. 3000 E. Balto.		25D. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2840	
BIRTH NO. 65 2840		CERTIFICATE OF DEATH		Registered No. 65 2840	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Henry John Weider Sr.			2. DATE AND HOUR OF DEATH March 12, 1965 10A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fayette Convalescent Home			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 111 N. Decker Avenue		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/22/90	9. AGE (In years last birthday) 74	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry J. Weider			14. MOTHER'S MAIDEN NAME Genevieve Bolz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 213-07-6086		
			17. INFORMANT ADDRESS Barbara A. Weider 111 N. Decker Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH Carcinoma nose		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 1 1965 to March 12 1965, that (I) (we) last saw the deceased alive on March 1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles C. MacMin N M.D.			23B. DATE SIGNED Mar 15, 1965		
23C. PHYSICIAN'S NAME (Type) CHARLES C. MACMIN N M.D.			23D. ADDRESS 2900 E. Baltimore St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/65		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965			
25B. NAME OF REGISTRAR Robert E. Jones		25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Balto. St.			



42-27-40

FR

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

65 2841

BIRTH NO.

65 2841

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Margaret Scott

2. DATE AND HOUR OF DEATH

March 12, 1965

9:35 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1413 Rayleigh Way 21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

11-26-93

9. AGE (In years  
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John T. Kelly

14. MOTHER'S MAIDEN NAME

Catherine Muldowney

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, assthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Fracture of Femur

CAUSE OF DEATH

Cerebral Vascular Accident

INTERVAL BETWEEN  
ONSET AND DEATH

Acute

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

12-64

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Fracture Hip

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID  
INJURY OCCUR?  
(If in Baltimore City, give exact location)

1413 Rayleigh Way

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
12 1 '64

21E. INJURY OCCURRED

While At  
WorkNot While  
At Work21F. HOW DID INJURY OCCUR?  
Slipped on rug.22. I certify that (I) (this hospital) attended the deceased from March 12, 19 65 to March 12, 19 65,  
that (I) (we) lost saw the deceased alive on March 12, 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Marvin Schuster

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

March 12, 1965

23C. PHYSICIAN'S  
NAME (Type)

Marvin Schuster

23D. ADDRESS

M.D.

4940 Eastern Avenue 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

3/17/65

24C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

MAR 16 1965

25B. NAME OF REGISTRAR

Robert E. Gable

25C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Balto. St.

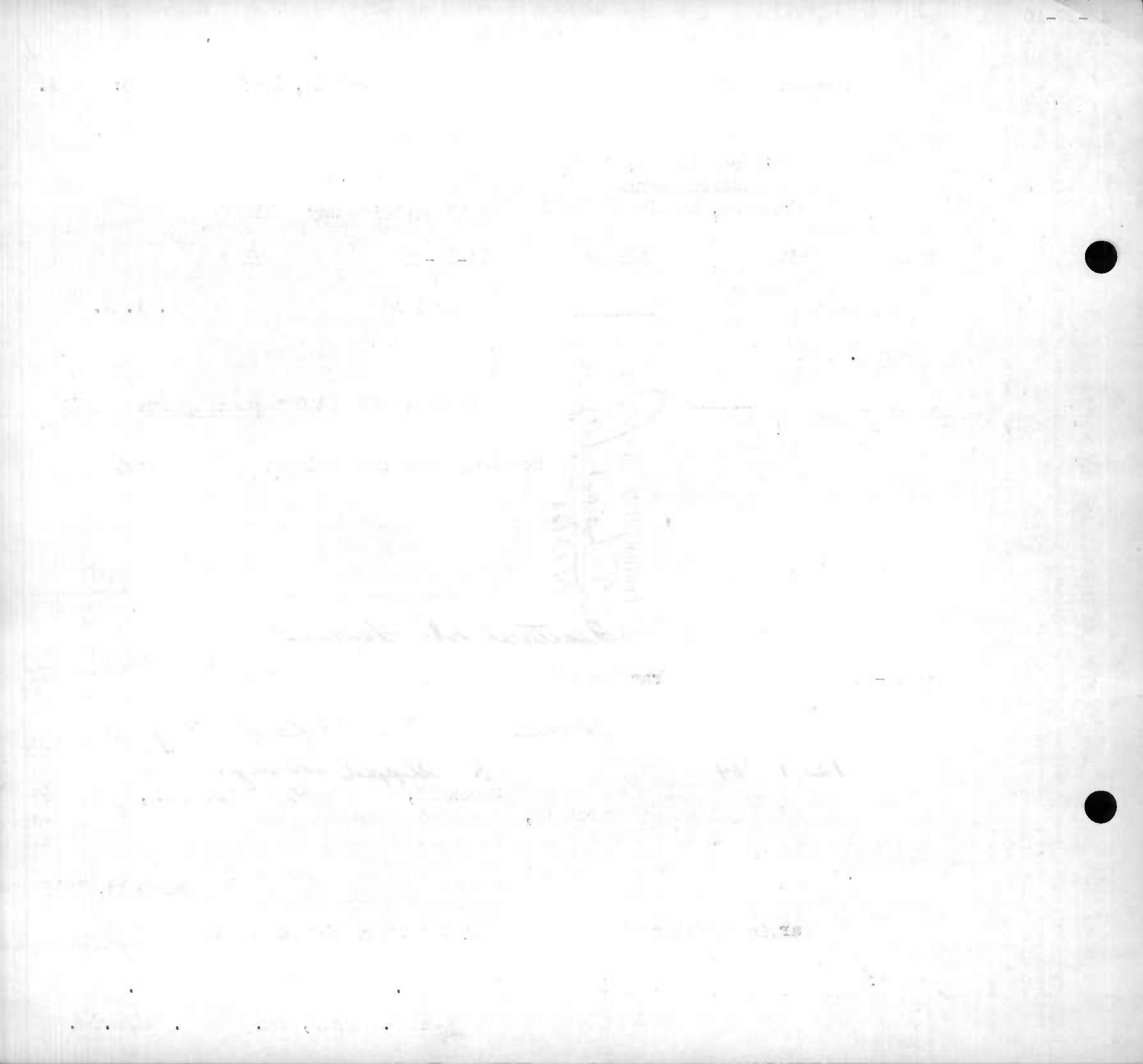
ADDRESS

N 821.0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

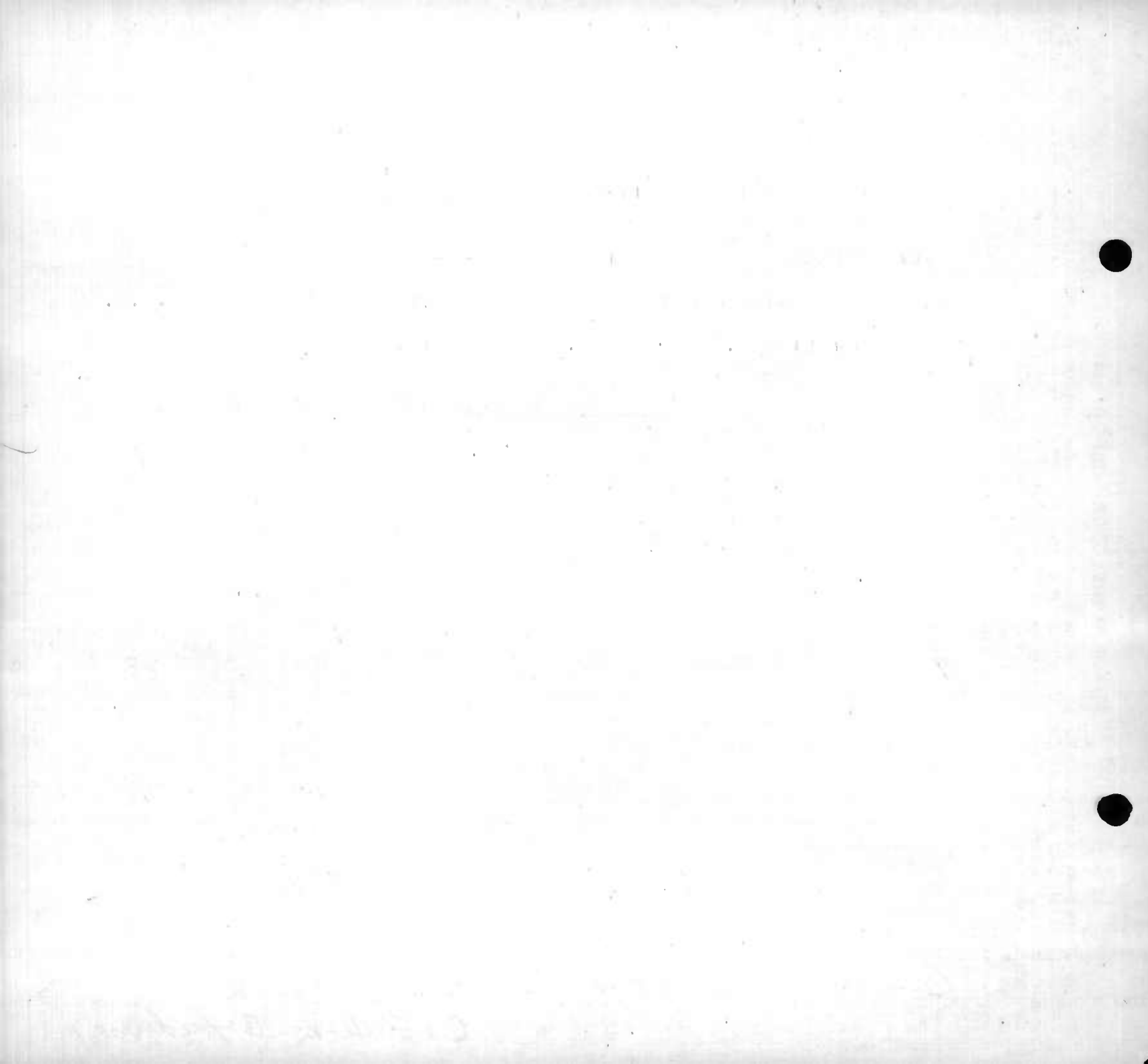




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

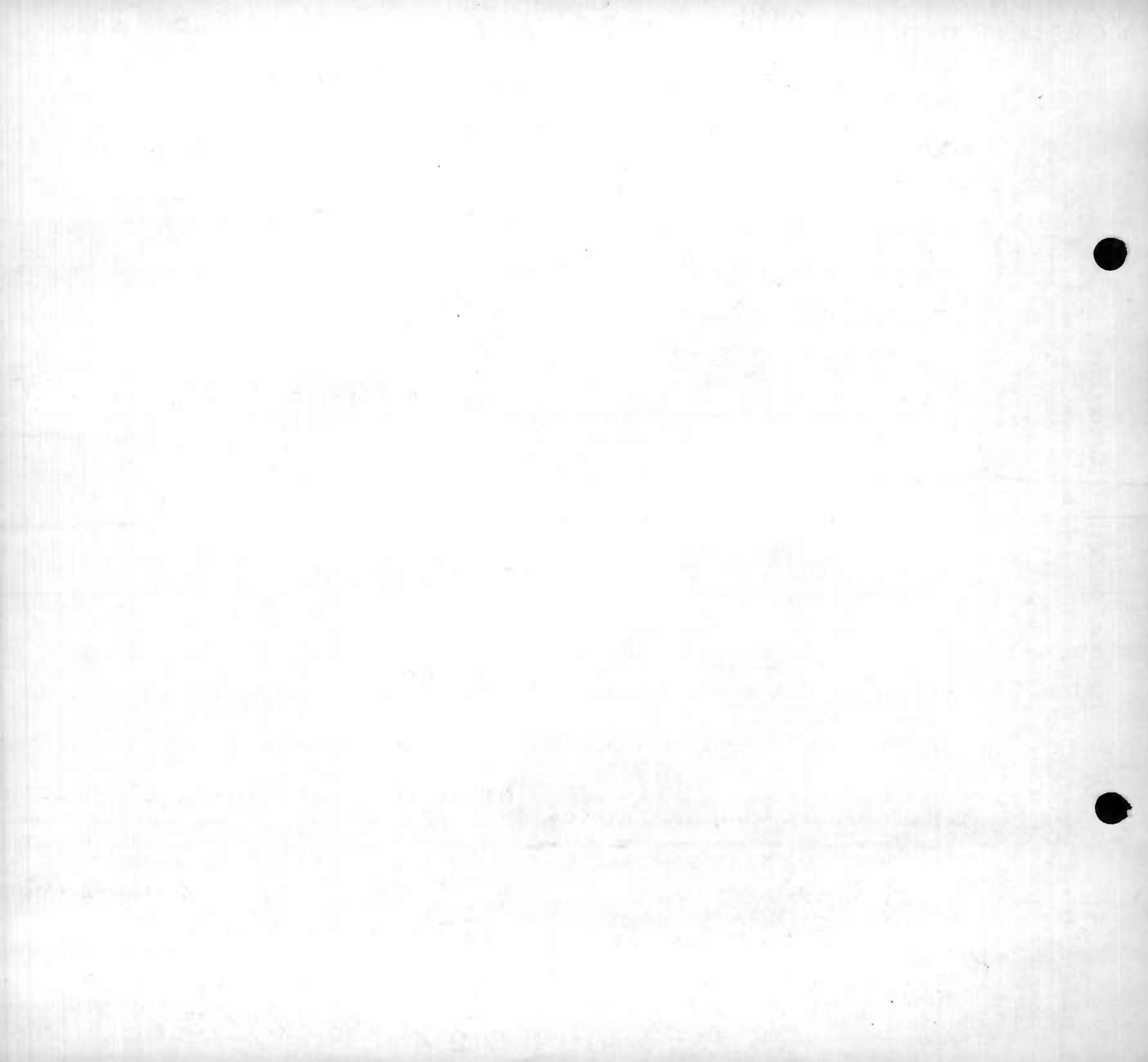
Baltimore City Health Department				BIRTH NO. 65 2842		Registered No. 65 2842	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) William H. Garner		2. DATE AND HOUR OF DEATH 7:40 AM 3/11/65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Frederick		5. CITY OR TOWN (If outside city limits, write RURAL and give township) FREDERICK 60-11	
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL				6. STREET ADDRESS (If rural, give location) 203 PHEBUS AVENUE			
6. SEX MALE	7. RACE NEGRO	8. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	9. DATE OF BIRTH 3-8-95	10. AGE (In years lost birthday) 70	11. If Under 1 Yr. Months Days	12. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR OPERATOR			10B. KIND OF BUSINESS OR INDUSTRY HOTEL		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM H. GARNER, SR.			14. MOTHER'S MAIDEN NAME HARRIET WEEDEN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mary F. Garner - 203 Phebus Ave		
18. 14501 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) acute hemorrhage neck (B) erosion large artery (C) Ca tonsil			INTERVAL BETWEEN ONSET AND DEATH 1 1/4 hr same 3 wks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2/18/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED cancer tonsils + mouth		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/18 1965 to 3/11 1965, that (I) (we) lost saw the deceased alive on 3/10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Paul M. Leand				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/11/65	
23C. PHYSICIAN'S NAME (Type) PAUL M. LEAND				23D. ADDRESS Johns Hopkins Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-15-65		24C. NAME OF CEMETERY or CREMATORY St John		24D. LOCATION (City, town, or county) (State) Frederick md	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR C. B. Hicks - III		ADDRESS Frederick, md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2843</u>	
BIRTH NO. <u>65 2843</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>VIOLA M. WHITE</u>		2. DATE AND HOUR OF DEATH <u>3-15-65</u> <u>3</u> A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>8-06</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>1623 N. Wolfe ST.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO.</u>			
		D. STREET ADDRESS (If rural, give location) <u>1623 N. Wolfe ST.</u>			
5. SEX <u>F</u>	6. RACE <u>C.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5-2-97</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAUNDRESS (R)</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>	
13. FATHER'S NAME <u>SAMUEL MOORE</u>		14. MOTHER'S MAIDEN NAME <u>?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John H. White</u> ADDRESS <u>1623 N. Wolfe ST</u>	
18. <u>421.4</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Chronic Valvular Heart Disease</u>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 11</u> <u>1964</u> to <u>March 15</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>March 14</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>F. K. Adams</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>March 16-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>F. K. ADAMS</u>		23D. ADDRESS M.D. <u>1222 N. Caroline St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-18-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. CALVARY</u>	
24D. LOCATION (City, town, or county) (State) <u>A. A. County, MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Joseph J. Block</u> ADDRESS <u>1304 N. Central</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2844		BALTIMORE HEALTH DEPARTMENT		Registered No. 65 2844	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Stacey Saunders (Fenwick)		2. DATE AND HOUR OF DEATH 3-12-65 1030 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 2 D. STREET ADDRESS (If rural, give location) 200 N. AISQUITH ST., APT. 9D			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	B. DATE OF BIRTH 1-13-65	9. AGE (In years lost birthday) 2 MONTHS	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME RONALD SAUNDERS			
14. MOTHER'S MAIDEN NAME GENEVIEVE FENWICK		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Genevieve F. Saunders 200 N. Aisquith St.			
18. 754.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ? Generalized Sepsis DUE TO (B) Congenital heart disease DUE TO (C) Status epilepticus.		INTERVAL BETWEEN ONSET AND DEATH 6 days. Birth	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No		20A. AUTOPSY? (Yes or No) Yes.	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-3-65-19 to 3-12-65-19, that (I) (we) lost saw the deceased alive on 3-12-65-19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Russell S. - Jones		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-12-65-	
23C. PHYSICIAN'S NAME (Type) Russell S. Jones		23D. ADDRESS Johns Hopkins Hospital.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem	
24D. LOCATION (City, town, or county) (State) A.D. County Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965			
25B. NAME OF REGISTRAR Robert E. Stachurski		25C. FUNERAL DIRECTOR Milton E. Eickman 1297 N. Calver			

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20-1-1

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20-1-1



65 2845

BALTIMORE CITY HEALTH DEPARTMENT

65 2845

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

John Fleming

2. DATE AND HOUR PRONOUNCED DEAD

March 13, 1965 2:00 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1737 E. North Avenue

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1737 E. North Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

12-11-1936

9. AGE (In years  
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CANNER

10B. KIND OF BUSINESS OR INDUSTRY

Food

11. BIRTHPLACE (State or foreign country)

BALTIMORE, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

CECIL FLEMING

14. MOTHER'S MAIDEN NAME

GRACE JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

GRACE L. FLEMING  
1737 E. NORTH AVE.

ADDRESS

18. E962.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Chronic Urinary Tract Infection  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Quadraplegia  
DUE TO  
Fracture of Cervical Vertebrae with  
(C) Compression of Spinal Cord.

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

Unknown

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

1957

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Fell down stairs.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
3/14/6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/18/65

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

Westport, Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 16 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

William E. Blighman

ADDRESS

1129 N. CAROLINE

12-11-1958  
Baltimore, Md.  
Grace Johnson  
Grace Johnson

Sample  
Found  
Cecil Fleming  
No. 3

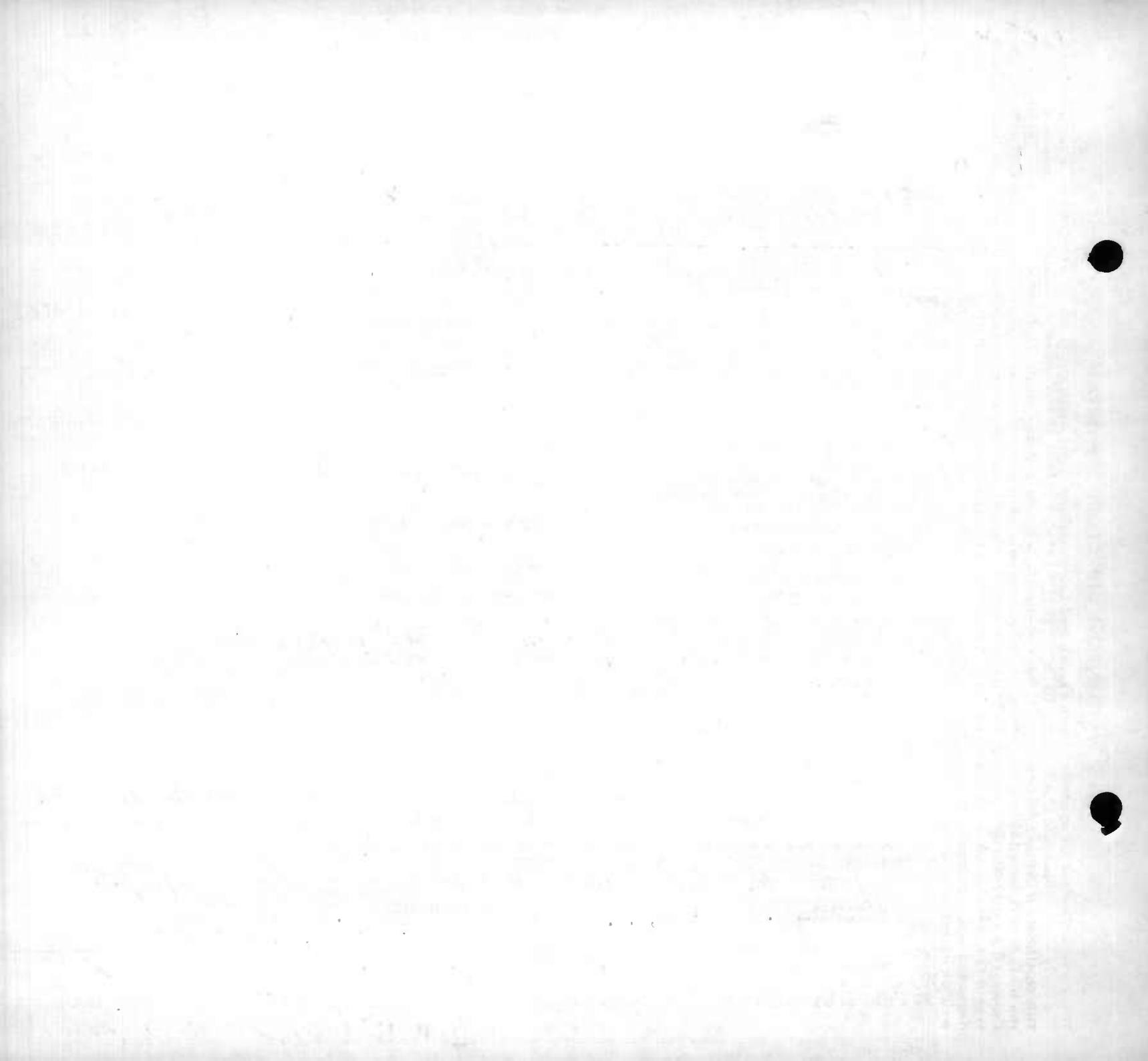
Class, 1958

Byrd 3/16/58 Mt. Auburn Cem. Westport,  
N.Y. 11580

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2846		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2846	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Lucy Marie</i>		2. DATE AND HOUR OF DEATH <i>March 11/65 8:10 P. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <i>MD</i> B. COUNTY <i>8-03</i>			
<i>1513 Milton Ave. BALTIMORE</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>1513 Milton Ave</i>			
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Jan 27, 1901</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>M. C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i>		13. FATHER'S NAME <i>Stephenie Stacks</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hattie Singleton</i> ADDRESS <i>1513 Milton Ave</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO (B) <i>BENIGN Essential Hypertension</i> DUE TO (C) <i>years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>BENIGN Essential Hypertension</i>					
19A. DATE OF OPERATION <i>D NONE</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <i>NONE</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>January 20</i> 19 <i>65</i> to <i>March 11</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>March 8</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John H. Daughtery, M.D.</i>		23B. DATE SIGNED <i>3/13/65</i>		23C. PHYSICIAN'S NAME (Type) <i>John H. Daughtery, M.D.</i>	
		23D. ADDRESS <i>2443 E. Preston Street Baltimore, Maryland 21213</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>March 13/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Glenn H. Cashner</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		24E. DATE REC'D BY HEALTH DEPT. <i>MAR 16 1965</i>		24F. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
24G. FUNERAL DIRECTOR <i>John E. Elickson</i>		24H. ADDRESS <i>1129 N. Calhoun St</i>			



BIRTH NO. 65 2847		BALTIMORE CITY HEALTH DEPARTMENT		65 2847	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>KING S. PARKER</b>			2. DATE AND HOUR PRONOUNCED DEAD <b>March 13, 1965 4:40 P M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bon Secour Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2013 W. Saratoga St.</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>June 22, 1914</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Chemical Plant</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
13. FATHER'S NAME <b>Charles Parker</b>			14. MOTHER'S MAIDEN NAME <b>Helen Bonds</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-46-3566</b>		17. INFORMANT <b>Marjorie Parker</b>	
				ADDRESS <b>2013 W. Saratoga St.</b>	
18. CAUSE OF DEATH <b>E 900.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>(A) Right Subdural Hematoma and Fractured Skull.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B) DUE TO</b> <b>(C)</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>4 S. Payson Street</b>	
21D. TIME OF INJURY (APPROX.) <b>3 12 '65 P</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell down stairs.</b>	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <del>XXXXXX</del> <b>Accident</b> <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3/14/65</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>3/17/1965</b>		23C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
23D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		24A. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
		24C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		ADDRESS <b>319 N. Schwartz St.</b>	

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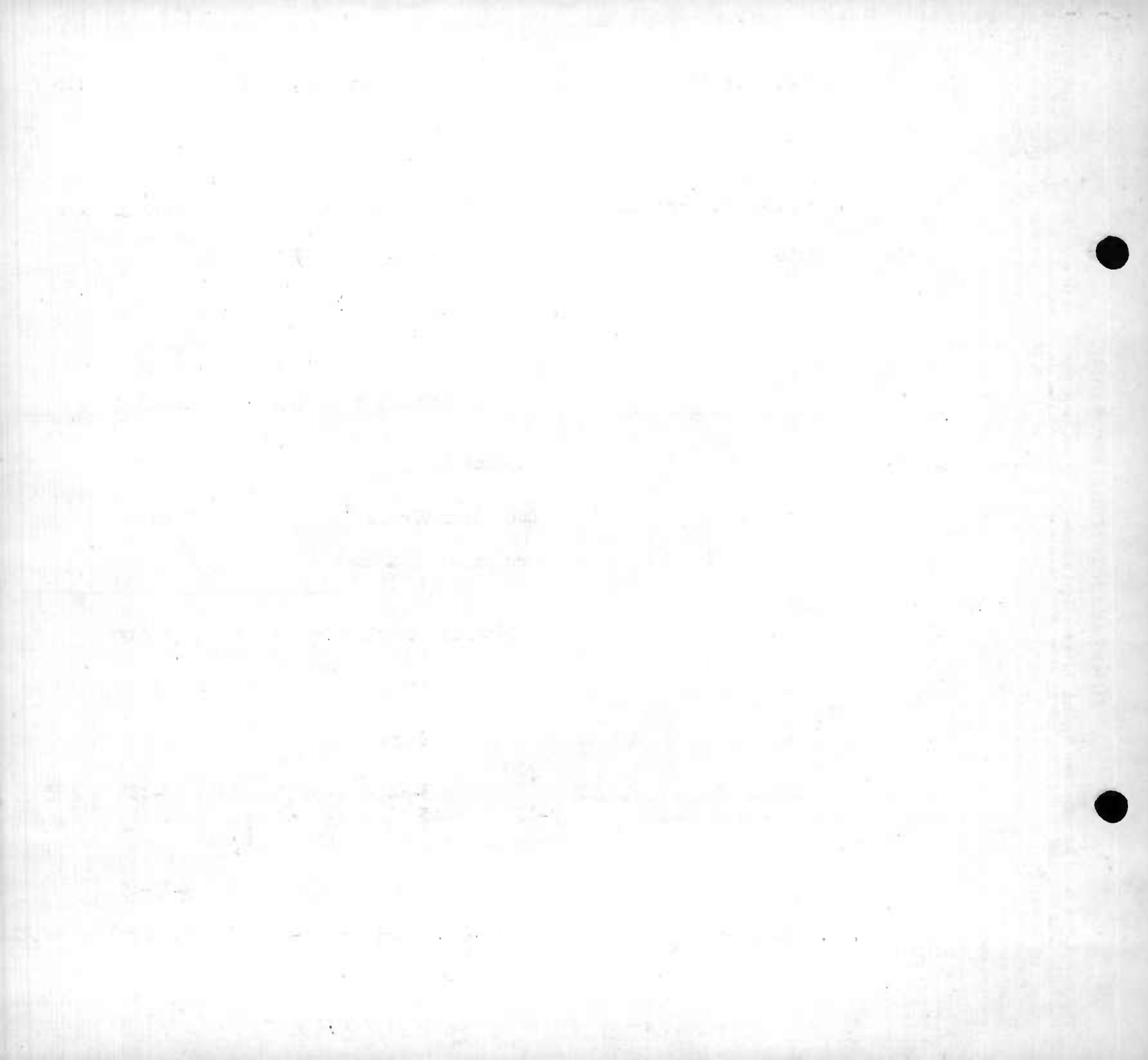


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2848</b>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b>		Registered No. <b>65 2848</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Elizabeth Morris</b>			2. DATE AND HOUR OF DEATH <b>March 13, 1965</b> <b>5:15 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-11</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3520 Hilton Road (Ashburton Nursing Home)</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>9-27-1887</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>PHAFF</b>		
14. MOTHER'S MAIDEN NAME <b>?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>RECORDS-4940 Eastern Avenue-#21224</b>			ADDRESS		
18. <b>715 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <b>Septicemia</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
			(B) <b>Decubitus Ulcers</b> DUE TO		<b>weeks</b>
			(C) <b>Prolonged Bed Rest</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>Digitalis Intoxication</b>		<b>2 days</b>
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-12</b> 19 <b>65</b> to <b>3-13</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3-13</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) <b>Dr. M. Schuster</b>				23B. DATE SIGNED <b>3-13-65</b>	
23D. ADDRESS <b>4940 Eastern Avenue- Baltimore, Maryland #21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-17-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>LODGE PARK CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Stanley</b>		25C. FUNERAL DIRECTOR <b>WELBY FUNERAL HOME 5311 EDMONDSON AVE</b>			

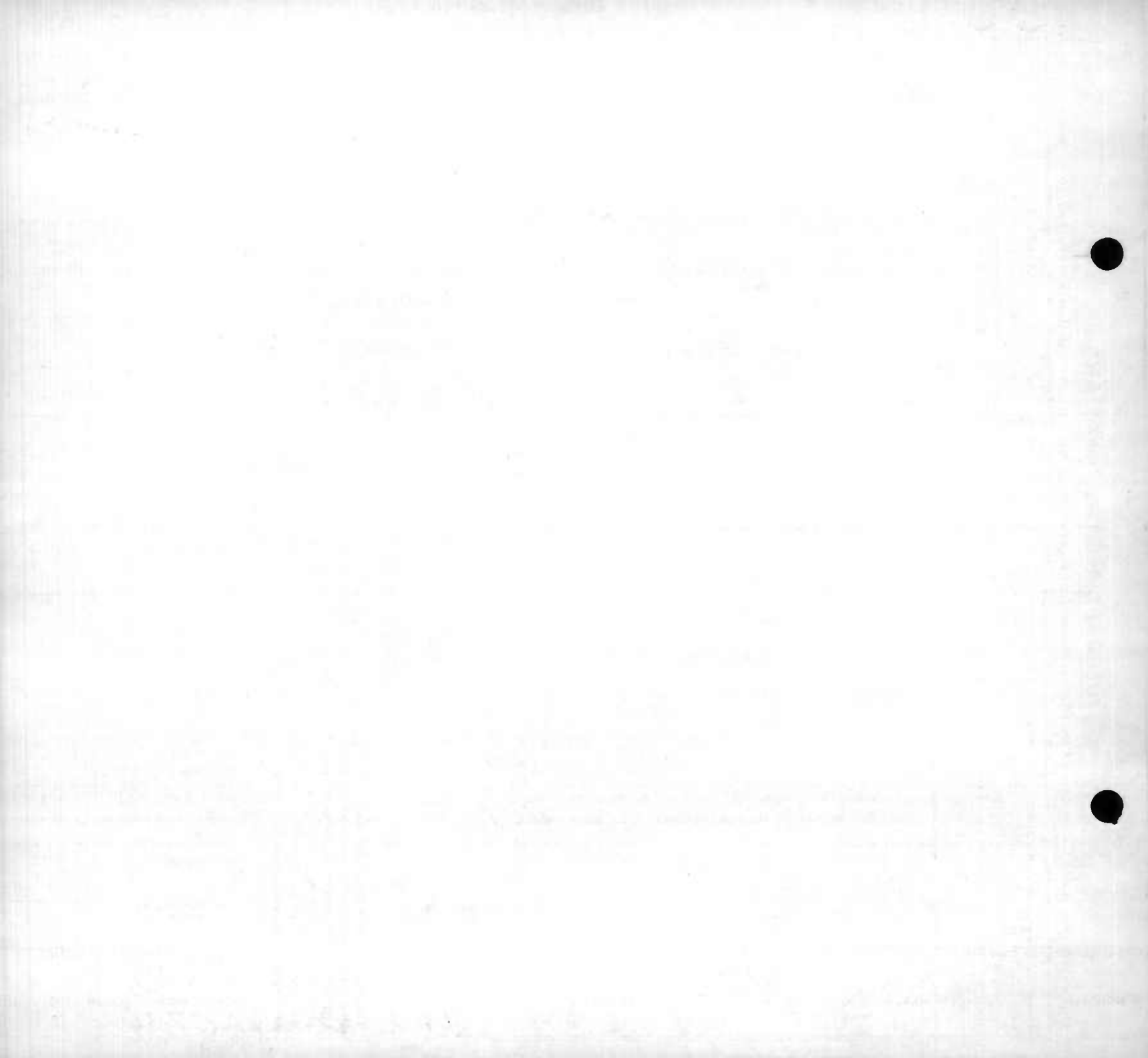




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2849</u>	
BIRTH NO. <u>65 2849</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>65 2849</u>					
1. NAME OF DECEASED (Type or Print) <u>Bowden Estelle</u>		2. DATE AND HOUR OF DEATH <u>3-14-65</u> <u>1:30 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>10 E. Henrietta St</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore Maryland</u>			
		D. STREET ADDRESS (If rural, give location)			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>EDWARD JEWELL</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET DAVIS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. THOMAS E. PARSONS 10 E MONTGOMERY</u>	
18. <u>422.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>ASCVD</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/11/1965</u> to <u>3/14/1965</u> , that (I) (we) last saw the deceased alive on <u>3/14/1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John Weagly</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3-14-65</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3/17/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>CHESTER CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>CHESTERTOWN, MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Stokely</u>		25C. FUNERAL DIRECTOR <u>JOHN F. DENNY, INC. 715 LIGHT ST.</u>	



1  
5.620

65 2850

BALTIMORE CITY HEALTH DEPARTMENT

65 2850

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) ROBERT WESLEY SCEARCE

2. DATE AND HOUR PRONOUNCED DEAD 3-8-65 12:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 4-01

D. STREET ADDRESS (If rural, give location) 402 W. Pratt Street 21201

5. SEX Male

6. RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married

8. DATE OF BIRTH 7-31-1911

9. AGE (In years last birthday) 43

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country) Tittsylvania County, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Benjamin Wesley Searce

14. MOTHER'S MAIDEN NAME Emma Jane Burnett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) Yes

16. SOCIAL SECURITY NO. \_\_\_\_\_

17. INFORMANT Family ADDRESS \_\_\_\_\_

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO Congestive heart failure

Mitral insufficiency

(B) DUE TO Old endocarditis

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. \_\_\_\_\_

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) \_\_\_\_\_

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) \_\_\_\_\_

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED 3-8-65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 3/8/65

23C. NAME OF CEMETERY or CREMATORY National Cemetery

23D. LOCATION (City, town, or county) (State) Danville, Virginia

24A. DATE REC'D BY HEALTH DEPT. MAR 16 1965

24B. NAME OF REGISTRAR Robert E. Tarkenton

24C. FUNERAL DIRECTOR Joseph N. Zannino, Jr.

ADDRESS 263 S. Cocking St.

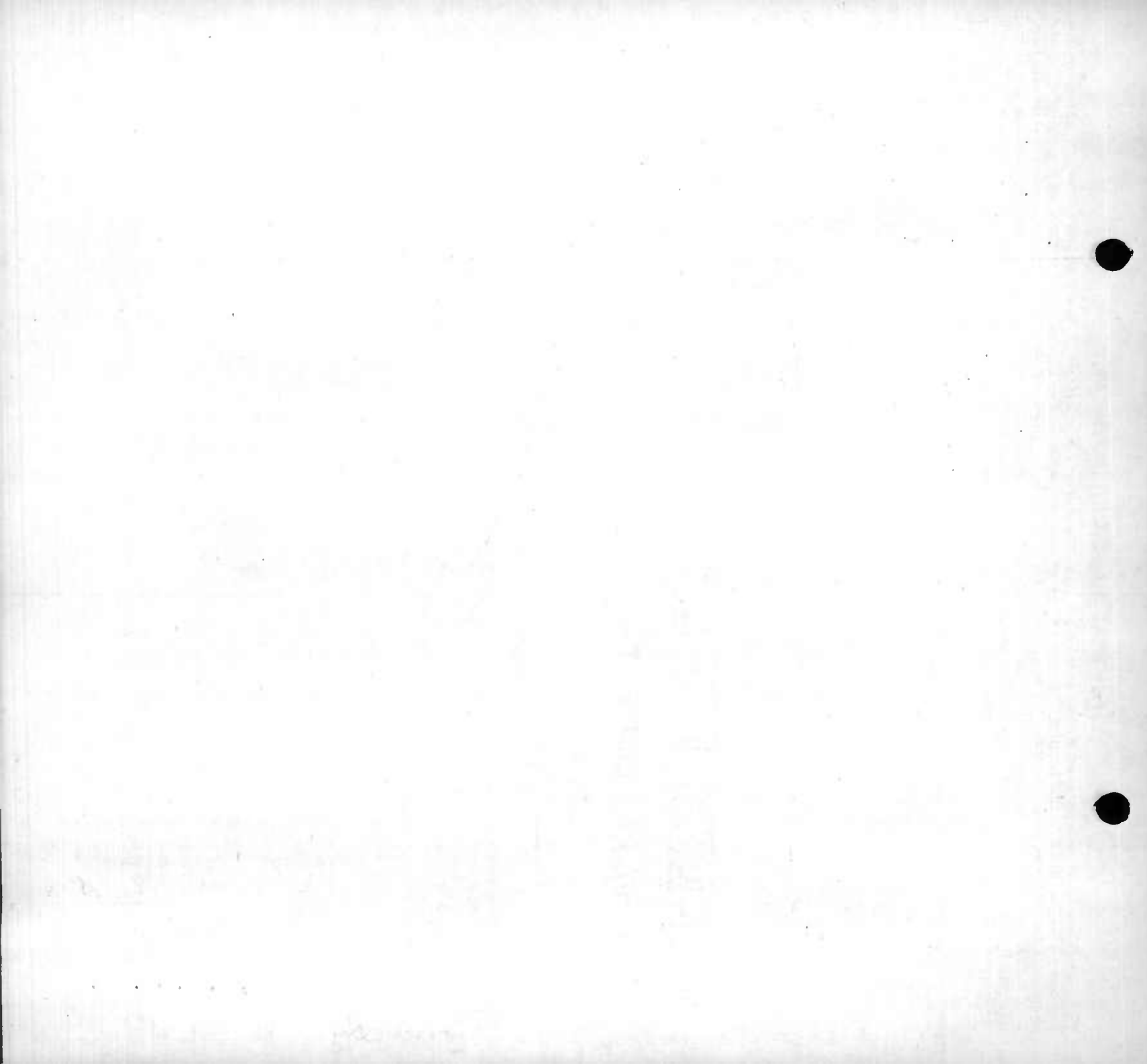
VS 151-REV. 1/1/65



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

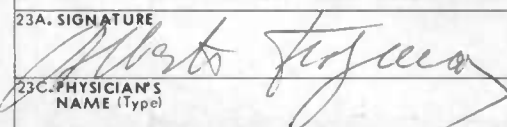
BIRTH NO. <b>65 2851</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2851</b>	
M.E. CASE NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Eckerl Mary Edith</b>		2. DATE AND HOUR OF DEATH <b>3/14/65 2:30 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Franklin Square Hospital</b>		A. STATE <b>B</b> B. COUNTY <b>Maryland</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>1809 Jackson St</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. <del>MARRIED</del> NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>10/24/98</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Harry Miller</b>		14. MOTHER'S M maiden NAME <b>Mary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family</b>	
				ADDRESS <b>Same</b>	
18. <b>420.1 I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Myocardial infarction</b> DUE TO			
ANTECEDENT CAUSES		(B) <b>Hypertensive cardiovascular disease, Uremia</b> DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/11</b> 19 <b>65</b> to <b>3/14</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3/14</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Byoung Koo Kim</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/14/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Byoung Koo Kim</b>		23D. ADDRESS <b>Franklin Square Hosp</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/17/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven</b>	
24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, A. A. Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 16 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>James C. Kelly</b>		ADDRESS <b>130 E. Fort Ave. City</b>			

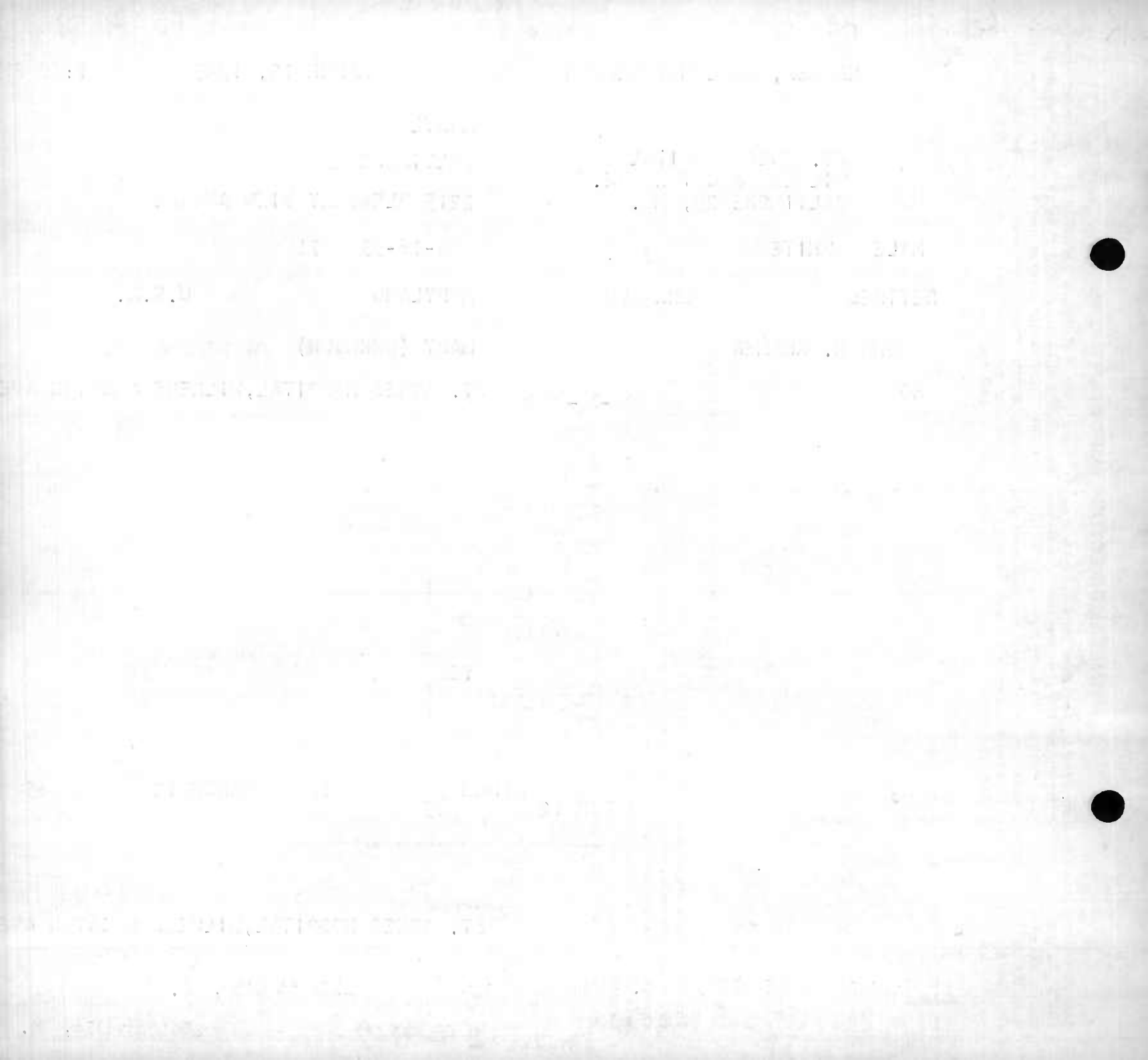




# FUNERAL DIRECTOR: IMPORTANT

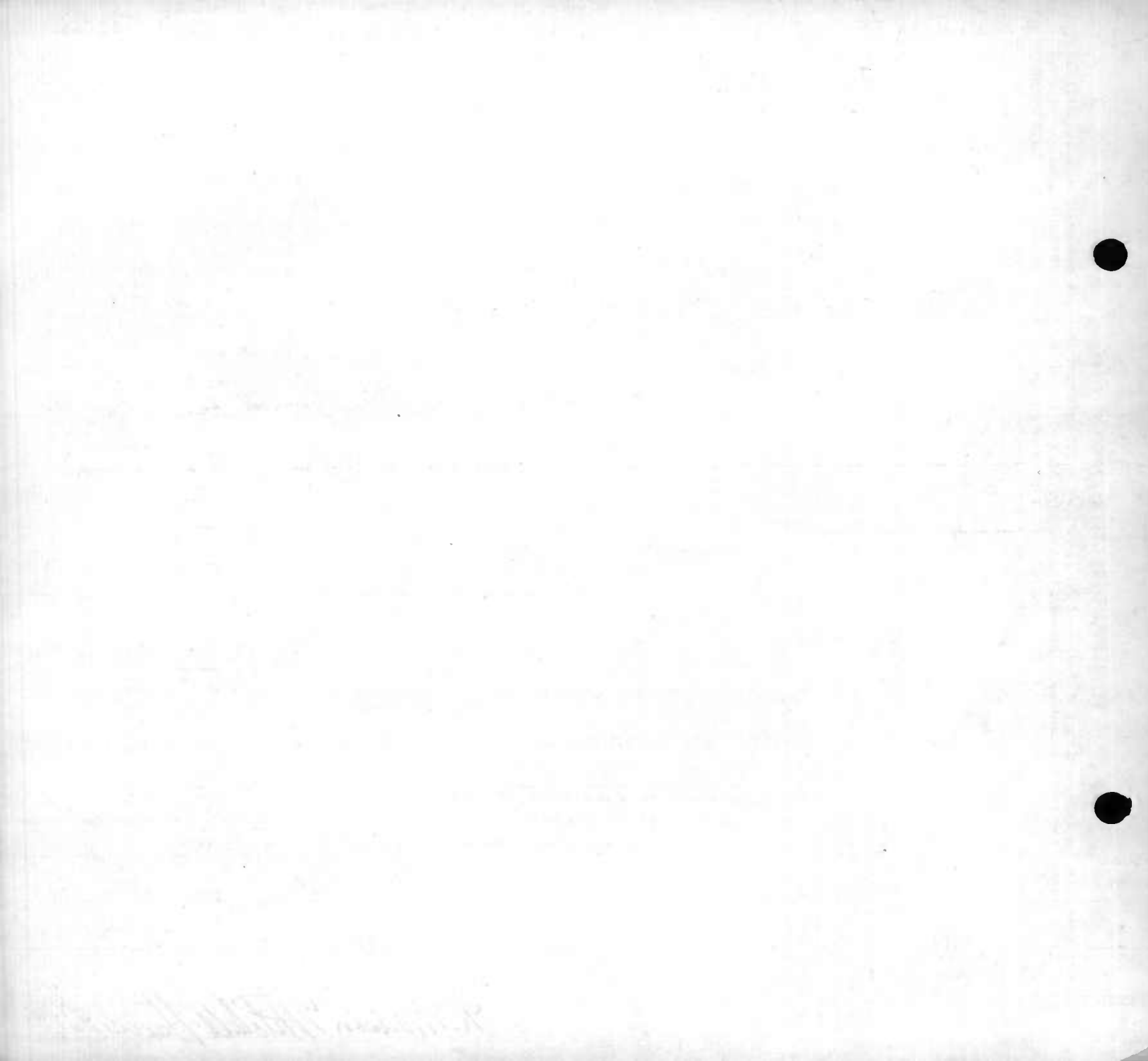
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2852		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2852	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH MARCH 12, 1965 1:55 PM	
1. NAME OF DECEASED (Type or Print) KRAMER, ADOLPHUS HERMAN					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE 29, MD.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21228 D. STREET ADDRESS (If rural, give location) 2215 PLEASANT VIEW AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 5-16-93	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOHN H. KRAMER		14. MOTHER'S MAIDEN NAME MARY (UNKNOWN) MARGARET WEISER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-16-2039		17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE	
18. 570.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Gastric ulcer (perforated) DUE TO (B) Perforated Peritonitis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 7 1965 to MARCH 12 1965, that (I) (we) last saw the deceased alive on MARCH 12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/13/65	
23C. PHYSICIAN'S NAME (Type) J. J. Jones, M.D.		23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/1965		24C. NAME of CEMETERY or CREMATORY St. Johns Cemetery	
24D. LOCATION (City, town, or county) (State) Ellicott City, Md.					
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1965		25B. NAME OF REGISTRAR Robert E. Jones, M.D.		25C. FUNERAL DIRECTOR Eastern Funeral Home	
25D. ADDRESS Catonsville, Md.					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



# FUNERAL DIRECTOR: IMPORTANT

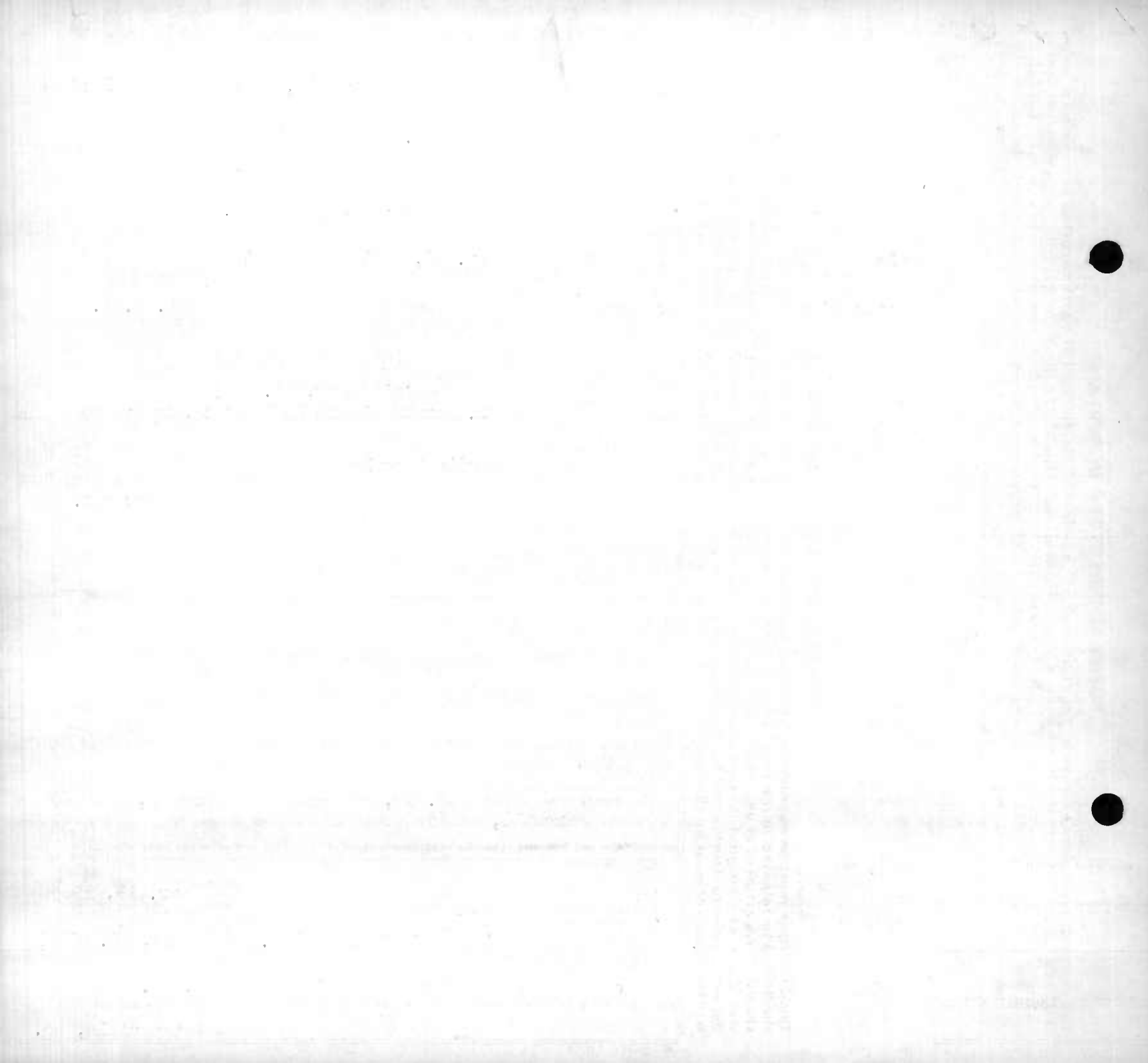
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 2854

BIRTH NO. <u>65 2854</u>		2. DATE AND HOUR OF DEATH <u>March 13, 1965</u> <u>12:40 A.M.</u>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>MARGARET M. ALCORN</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Windsor Rest Home</u> <u>3025 Windsor Ave.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 21203</u> D. STREET ADDRESS (If rural, give location) <u>1401 Inverness Avenue</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>Nov. 20, 1877</u>
9. AGE (In years last birthday) <u>87</u>		10. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Albert Arrington</u>		14. MOTHER'S MAIDEN NAME <u>Jane Ann Arrington</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Baltimore, Md. 21230</u> <u>Mr. Howard Alcorn 1401 Inverness Avenue</u>		ADDRESS	
18. <u>442X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cardio Vascular</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Renal Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Few yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 17, 1965</u> to <u>March 3, 1965</u> , that (I) (we) last saw the deceased alive on <u>March 12, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE <u>William R. Johnson</u>		23B. DATE SIGNED <u>Mar. 13, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>William R. Johnson</u>		23D. ADDRESS <u>403 Medical Arts Bldg. Baltimore, Md. 21201</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/15/1965</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Staley</u>	
25C. FUNERAL DIRECTOR <u>Windsor Rest Home</u>		ADDRESS <u>Catonsville, Md.</u>	

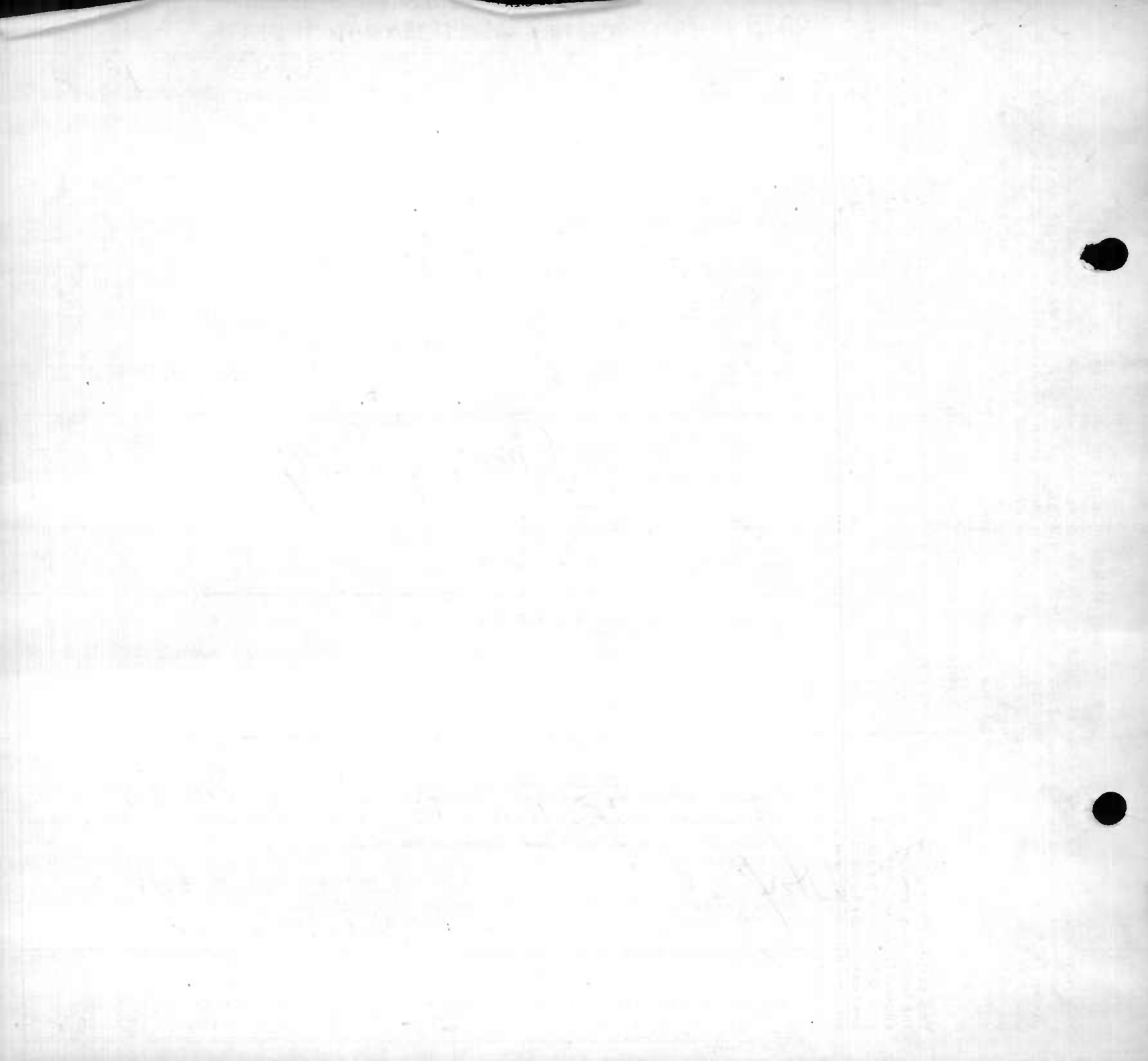


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2855				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2855	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH		130 A M.	
1. NAME OF DECEASED (Type or Print) Mary H. Stansbury				March 12, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		Md. Carroll			
4502 Roland Ave.		Baltimore, Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Hampstead	
				D. STREET ADDRESS (If rural, give location)		201 S. Main Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
Female	White	Single	March 10, 1874	91			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Retired School Teacher			Maryland		USA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Alpheus Stansbury				Matilda Hodges			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Mrs. Harry P. Cann		4502 Roland Ave. Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I				Cancer of Ovary		9 months	
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from March 11 19 65 to March 12 19 65, that (I) (we) last saw the deceased alive on March 11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		3-12-65	
				M.D. 5006 Roland Ave - 10			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3/15/65		Hampstead Cemetery		Hampstead, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 16 1965		Robert E. Sells, M.D.		Tipton-Elene		Funeral Home Hampstead, Md.	





R. 400

65 2856

BALTIMORE CITY HEALTH DEPARTMENT

65 2856

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH H. RILEY

2. DATE AND HOUR PRONOUNCED DEAD

March 10, 1965 12:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1735 E. 25th Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1-27-1919

9. AGE (In years last birthday)

46

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Roofers

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph Riley

14. MOTHER'S MAIDEN NAME

Daisy Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

WW II

16. SOCIAL SECURITY NO.

217-07-0165

17. INFORMANT

Irene Riley 1735 E. 25th St.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Lung with Cerebral Metastasis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hemorrhage within cerebral metastasis due to fall.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Company

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

National Gypsum Co., Newkirk St.

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

2

4

65

A

m.

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

Fell off roof.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/11/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

3-15-65

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION (City, town, or county) (State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 16 1965

24B. NAME OF REGISTRAR

Robert E. Barker, M.D.

24C. FUNERAL DIRECTOR

Delightful Phillips 1727 N. Mount St.

ADDRESS

955 FRONT ST

WALLING

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Chas. J.

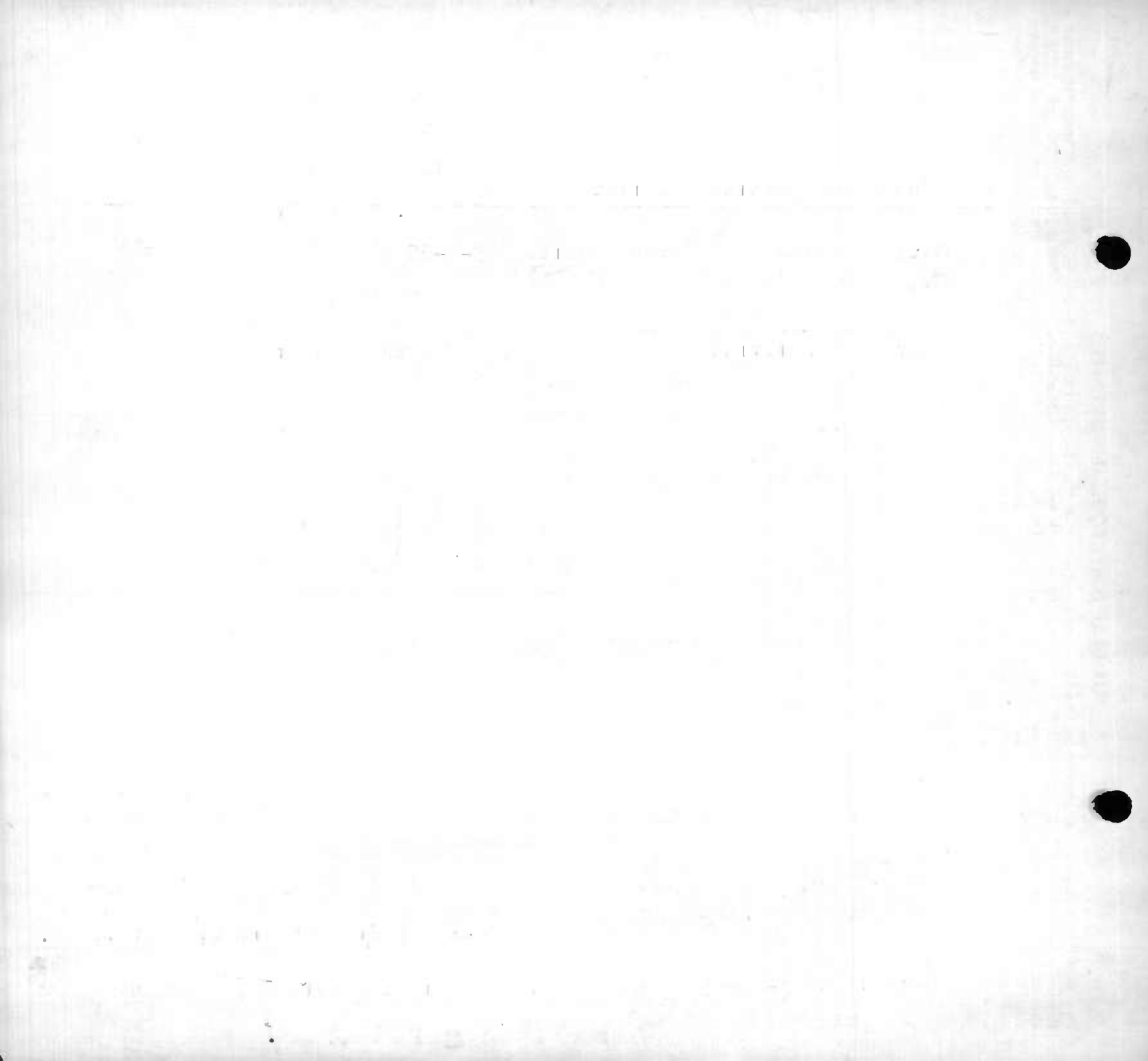
1-11-11

1-11-11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 2857</span>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <span style="font-size: 1.2em;">65 2857</span></p> <p>M.E. CASE NO. <span style="font-size: 1.2em;">114-89-23</span></p> <p>1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Baby Boy Christian</span></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3/14/65</span> <span style="float: right;">1 2<sup>10</sup> P.M.</span></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p style="text-align: center; font-size: 1.2em;">THE JOHNS HOPKINS HOSPITAL</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">7-03</span></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span></p> <p>D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">2310 E. EAGER ST</span></p>		
<p>5. SEX <span style="font-size: 1.2em;">MALE</span></p>		<p>6. RACE <span style="font-size: 1.2em;">NEGRO</span></p>		<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">NEVER MARRIED</span></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span></p>	
<p>13. FATHER'S NAME <span style="font-size: 1.2em;">RAYMOND CHRISTIAN</span></p>			<p>14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">BARBARA SHORT</span></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS</p>	
<p>18. <span style="font-size: 1.2em;">763.0 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">CAUSE OF DEATH</p> <p>(A) <span style="font-size: 1.2em;">Cardiac Arrest</span> DUE TO</p> <p style="text-align: center;">INTERVAL BETWEEN ONSET AND DEATH</p> <p style="text-align: center;">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(B) <span style="font-size: 1.2em;">Respiration Pneumonia, Hyaline Membrane Disease</span> DUE TO</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">March 9</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">March 14</span> 19 <span style="font-size: 1.2em;">65</span>, that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">March 14</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <span style="font-size: 1.2em;">Richard H. Heller</span></p>				<p>23B. DATE SIGNED <span style="font-size: 1.2em;">3/14/65</span></p>	
<p>23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Richard H. Heller</span></p>				<p>23D. ADDRESS M.D. <span style="font-size: 1.2em;">JOHNS HOPKINS HOSPITAL, BALTO., MD.</span></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">CREMATION</span></p>		<p>24B. DATE <span style="font-size: 1.2em;">3-15-65</span></p>		<p>24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND</span></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAR 16 1965</span></p>		<p>25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span></p>		<p>25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">2862</span></p>	



R. 263

65 2858

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2858

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EMMA (Saunders) RICHARDSON

2. DATE AND HOUR PRONOUNCED DEAD

March 12, 1965 11:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

853 W. Franklin Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 4 - 1906

9. AGE (In years last birthday)

58

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry William Taylor

14. MOTHER'S MAIDEN NAME

Mary Ann Saunders

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

216-20-3944

17. INFORMANT

Herbert Richardson

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/13/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

3-17-1965

23C. NAME OF CEMETERY OR CREMATORY

Centenary Cemetery

23D. LOCATION (City, town, or county)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

MAR 16 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Charles Wilson - 1000 Brantley Ave

ADDRESS

March 1877

My dear Mr. [illegible]

I have just received your letter of the 14th inst.

and am glad to hear from you.

I am well and hope this finds you the same.

I have not much news to write at present.

I am, dear Mr. [illegible], very respectfully,

Your obedient servant,

[illegible signature]

Wm. [illegible] [illegible]

[illegible text]



B-460

65 2859

BALTIMORE CITY HEALTH DEPARTMENT

65 2859

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
OTHA A. BAYLOR		March 14, 1965 7:45 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1605 Madison Avenue	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Oct 22-1914
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY None	9. AGE (in years last birthday) 50
13. FATHER'S NAME Henry Baylor		11. BIRTHPLACE (State or foreign country) VA.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) WWII Yes		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Loretta A. Toliver	
17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Ethylism.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Arteriosclerotic Heart Disease.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner			
ACTUAL SIGNATURE Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER	
		ASSOCIATE MEDICAL EXAMINER	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	
Burial		3/18/1965	
23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Baltimore		Baltimore Md Md	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	
MAR 16 1965		Robert E. Taylor	
24C. FUNERAL DIRECTOR		24D. ADDRESS	
Clayton B. Brown		1000 Brewster Ave	



M 620

65 2860

BALTIMORE CITY HEALTH DEPARTMENT

65 2860

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT MARKS

2. DATE AND HOUR PRONOUNCED DEAD

March 6, 1965

12:55 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1313 N. Calvert Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

1931

9. AGE (In years  
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Flower Seller

10B. KIND OF BUSINESS OR INDUSTRY

Bellhop

11. BIRTHPLACE (State or foreign country)

Detroit, Mich.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Marks

14. MOTHER'S MAIDEN NAME

Rosie Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Flint Marks, Balto. Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Mucus plugging of tracheo-bronchial  
tree due to alcohol and barbiturate  
synergism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Fatty metamorphosis of liver, arteriosclerotic  
cardiovascular disease and chronic  
bronchitis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Unknown

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Unknown

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)  
3 6 65

21E. INJURY OCCURRED

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Ingested barbiturate while drinking

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-10-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Mar. 9, 1965

23C. NAME OF CEMETERY or CREMATORY

Loudon Park

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 16 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Joseph N. Zannino, 263 S. Conkling St.

24D. ADDRESS

WATKINS POLICE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

65 2861

Registered No.

65 2861

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)JOSEPH LEON ~~XXXXXXXX~~ HUDZIK

2. DATE AND HOUR PRONOUNCED DEAD

March 14, 1965 11:15 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2026 Bank Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2026 Bank Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Mar. 15, 1899

9. AGE (In years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Conductor

10B. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Hudzik

14. MOTHER'S MAIDEN NAME

Catherine Grajek

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

716-03-8931

17. INFORMANT

Silver Springs, Md. 20901  
Frank Hudzik - 412 Williamsburg Drive

ADDRESS

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)I  
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(A) Arteriosclerotic and Hypertensive  
Heart Disease.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Carcinoma of Larynx.

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/14/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/18/65

23C. NAME of CEMETERY or CREMATORY

St. Stanislaus

23D. LOCATION

Baltimore

(City, town, or county)

Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 17 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

George A. Weber

ADDRESS

George A. Weber - 705 S. Ann St.

#21231

Charles V. King

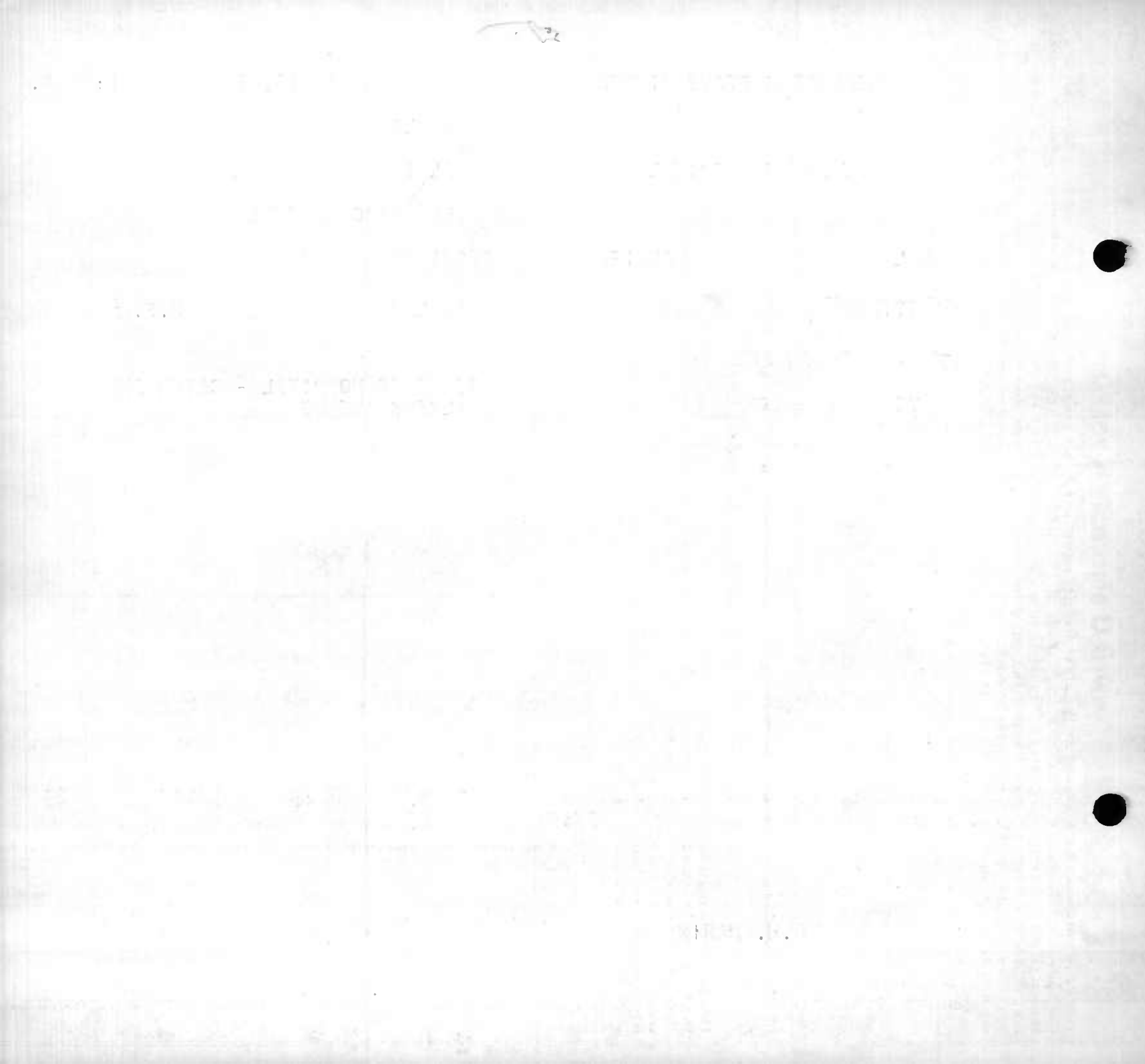


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

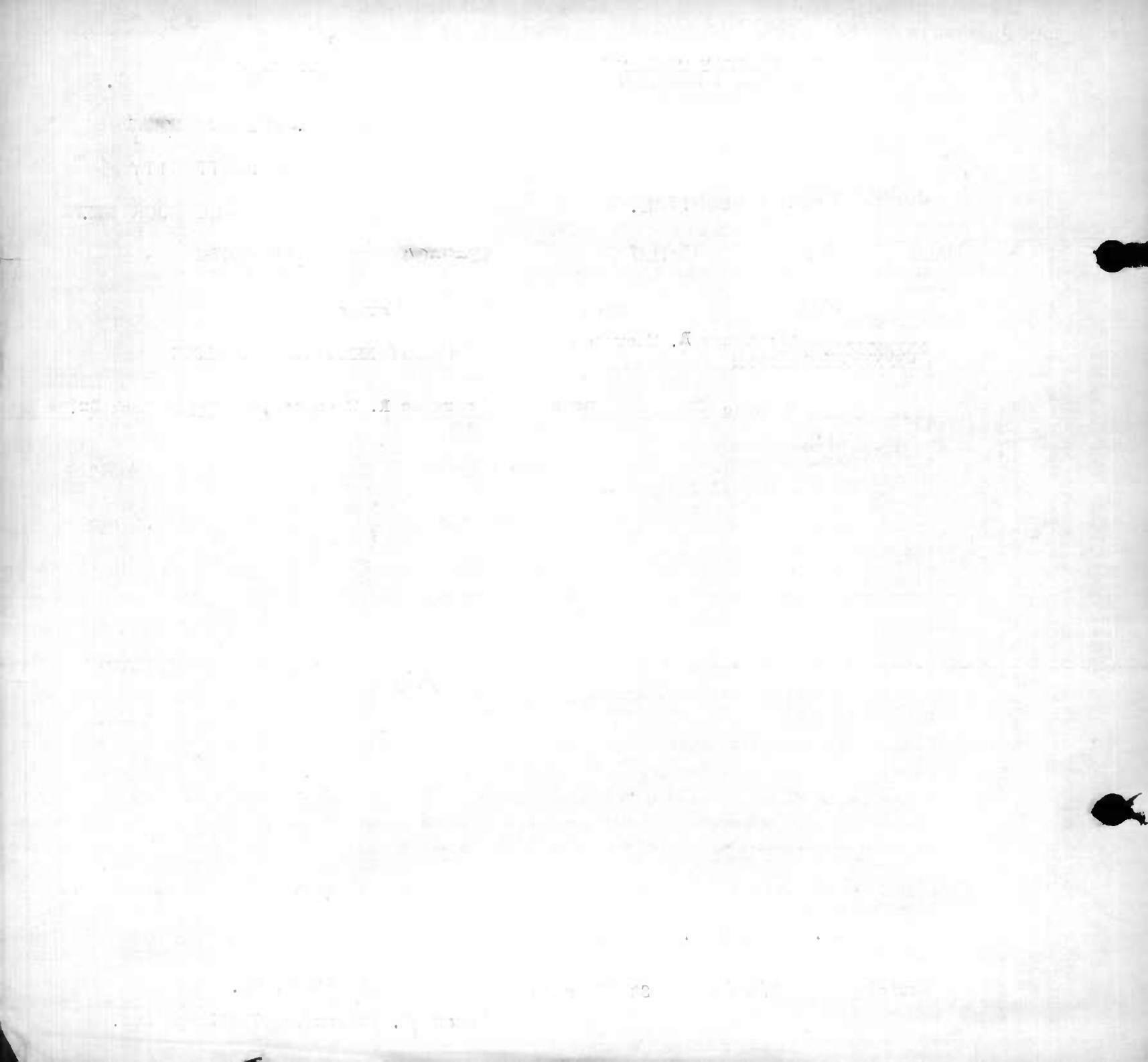
BIRTH NO. 65 2862				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2862	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>HERBERT GUSTAVE PIEPER</b>				2. DATE AND HOUR OF DEATH <b>MARCH 15, 1965 1:00 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>		B. COUNTY <b>Baltimore</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		53-00	
				D. STREET ADDRESS (If rural, give location) <b>1316 BIRCH AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>2/2/1896</b>	9. AGE (In years lost birthday) <b>69</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>Herbert Pieper</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W.W.I.</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>ST AGNES HOSPITAL - CATON AND WILKENS AVENUE</b>		ADDRESS
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Massive Cerebral Hemorrhage - Arterial Hypertension - Arteriosclerosis -</b>			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
18. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/15/1965</b> to <b>3/15/1965</b> , that (I) (we) last saw the deceased alive on <b>3/15/1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>R.H. MARIN</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/17/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>R.H. MARIN</b>				23D. ADDRESS <b>St Agnes Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/18/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Laudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 17 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Amalgamated 1328 Sulphur Spring Rd</b>		ADDRESS	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

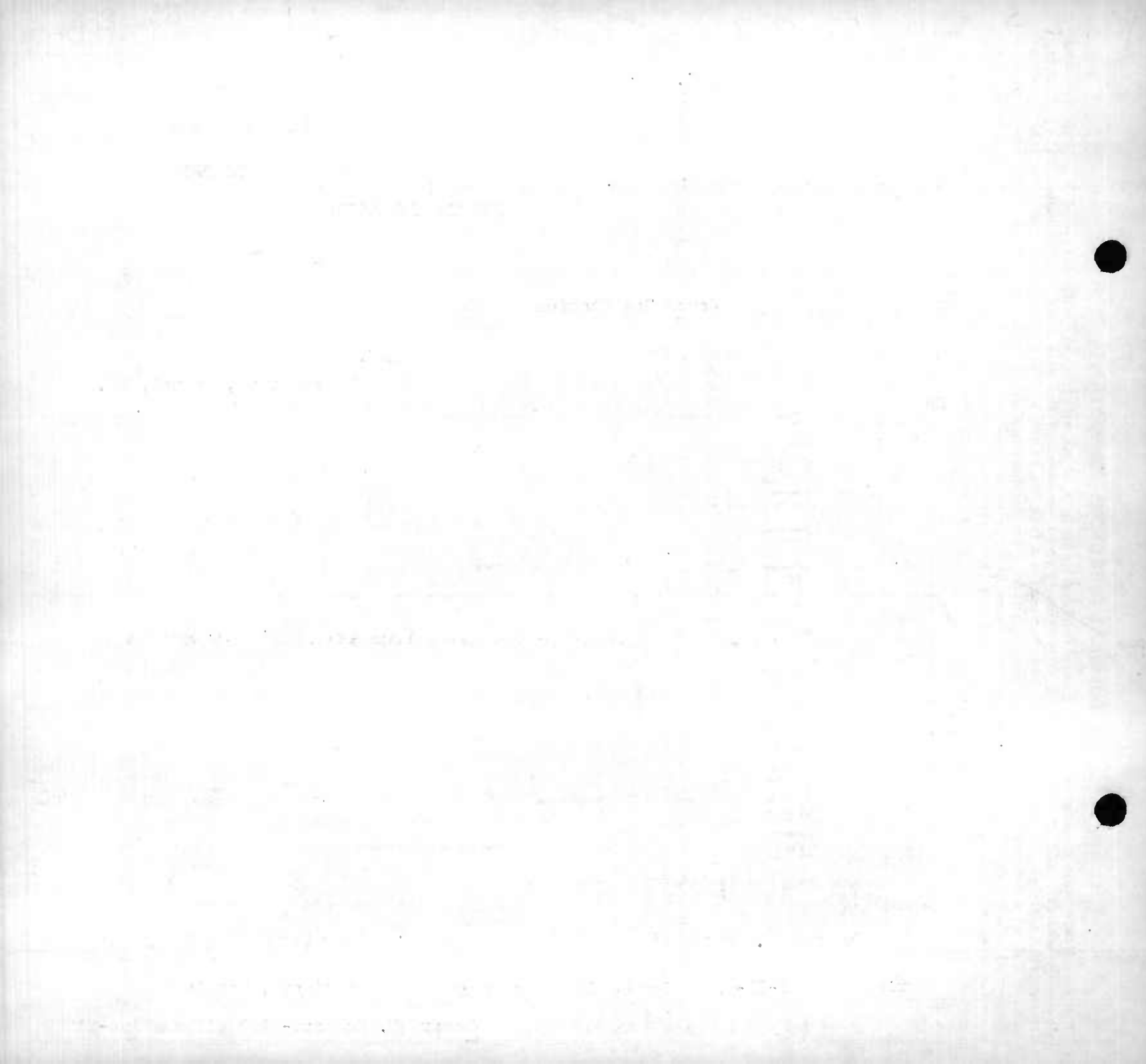
VS 150-REV. 1/1/65



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2864	
BIRTH NO. 65 2864		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>James R. Pleasant</b>		2. DATE AND HOUR OF DEATH <b>3/14/65 2<sup>05</sup> P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Montebello State Hospital</b>		A. STATE <b>Md.</b> B. COUNTY <b>Prince George</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>LAUREL 66-00</b>			
		D. STREET ADDRESS (If not, give location) <b>328 THOMAS DRIVE</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>9/6/08</b>	AGE (in years last birthday) <b>56</b>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Filling station</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Savon Gas Station</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>James M. Pleasant</b>		14. MOTHER'S MAIDEN NAME <b>NANNIE M. Davis</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>239-14-2247</b>		17. INFORMANT ADDRESS <b>328 Thomas Drive, Laurel, Md.</b> <b>Mary Sue Pleasant</b>	
18. <b>237X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrest</b>		CAUSE OF DEATH (A) DUE TO <b>Cardiac arrest</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>old posterior myocardial infarct</b>		(B) DUE TO <b>intracranial pressure</b>		(C) <b>intracranial neoplasm</b>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION <b>0</b>			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>3/1</b> 19 <b>65</b> to <b>3/14</b> 19 <b>65</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>3/14</b> 19 <b>65</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Robert W. Ireland</b>				23B. DATE SIGNED <b>3/14/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert W. Ireland</b>				23D. ADDRESS <b>Montebello State Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-17-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 17 1965</b>			
25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard-4107 Wilkens Ave-21229</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2865		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2865	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) BRANDT, HARRY G.		2. DATE AND HOUR OF DEATH MARCH 13, 1965		3:00AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL BALTO. 29, MD.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 28 D. STREET ADDRESS (If rural, give location) 5721 EDMONDSON AVE. -APT. C-5			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-10-97	9. AGE (In years last birthday) 67	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Traffic		10B. KIND OF BUSINESS OR INDUSTRY Chas. T. Brandt Co. Mgr.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES T. BRANDT		14. MOTHER'S MAIDEN NAME CATHERINE CRANE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 214-03-2488		17. INFORMANT ST. AGNES RECORDS Balto., Md. 21228 Mrs. Eva M. Brandt-5721 Edmondson Ave-Apt C-5	
18. 540.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Aspiration pneumonia 12-24 hrs. DUE TO (B) Spont. esophageal gast. ful. DUE TO (C) Gastric ulcer		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebrovascular accident & Acute myocardial infarct					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes - SAH	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 10 1965 to MARCH 13 1965, that (I) (we) last saw the deceased alive on MARCH 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William A. Deen Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED March 13, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-16-65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. MAR 17 1965			
24F. NAME OF REGISTRAR Robert E. Taylor		24G. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Ave-21229			

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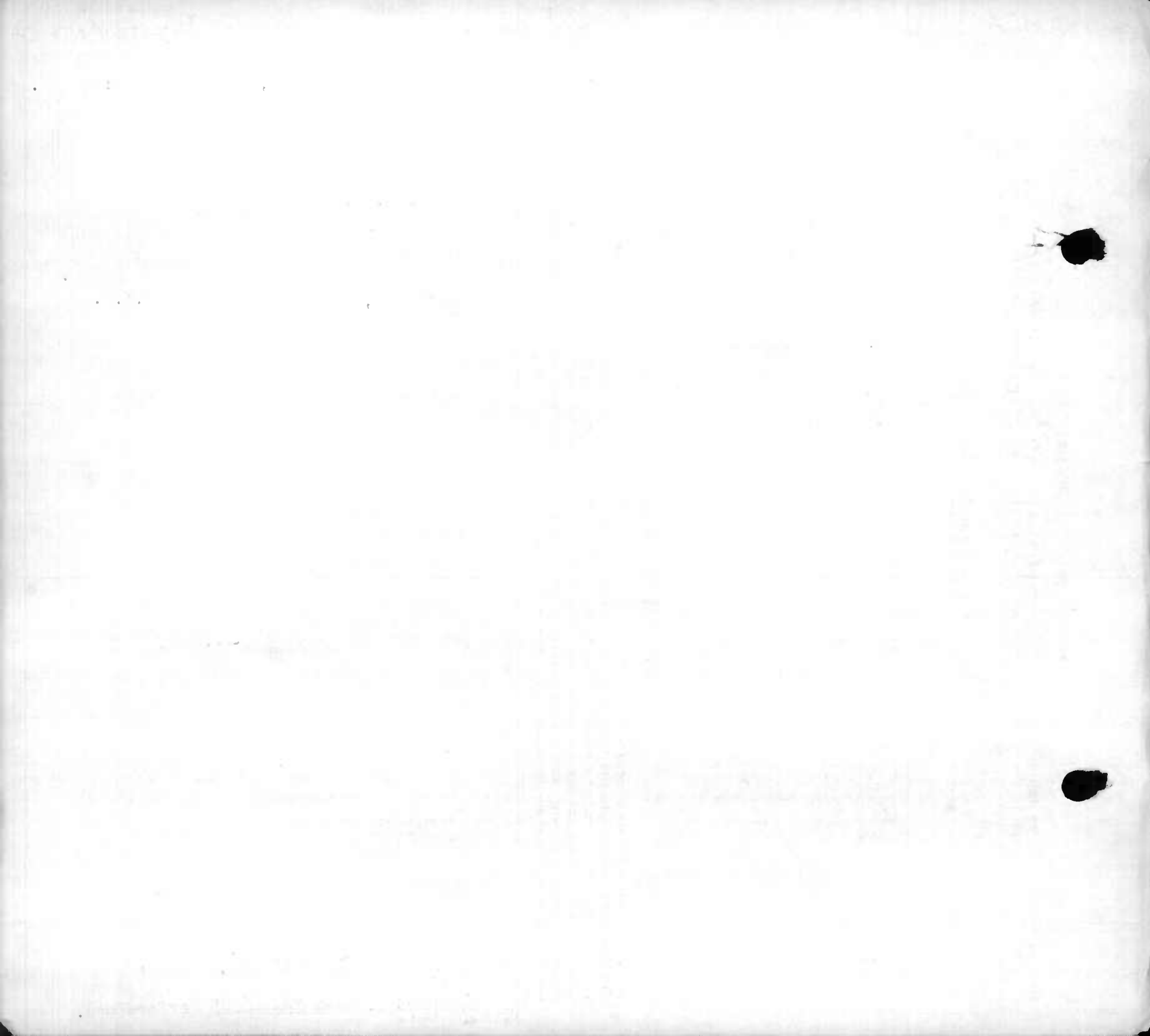
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# FUNERAL DIRECTOR: IMPORTANT

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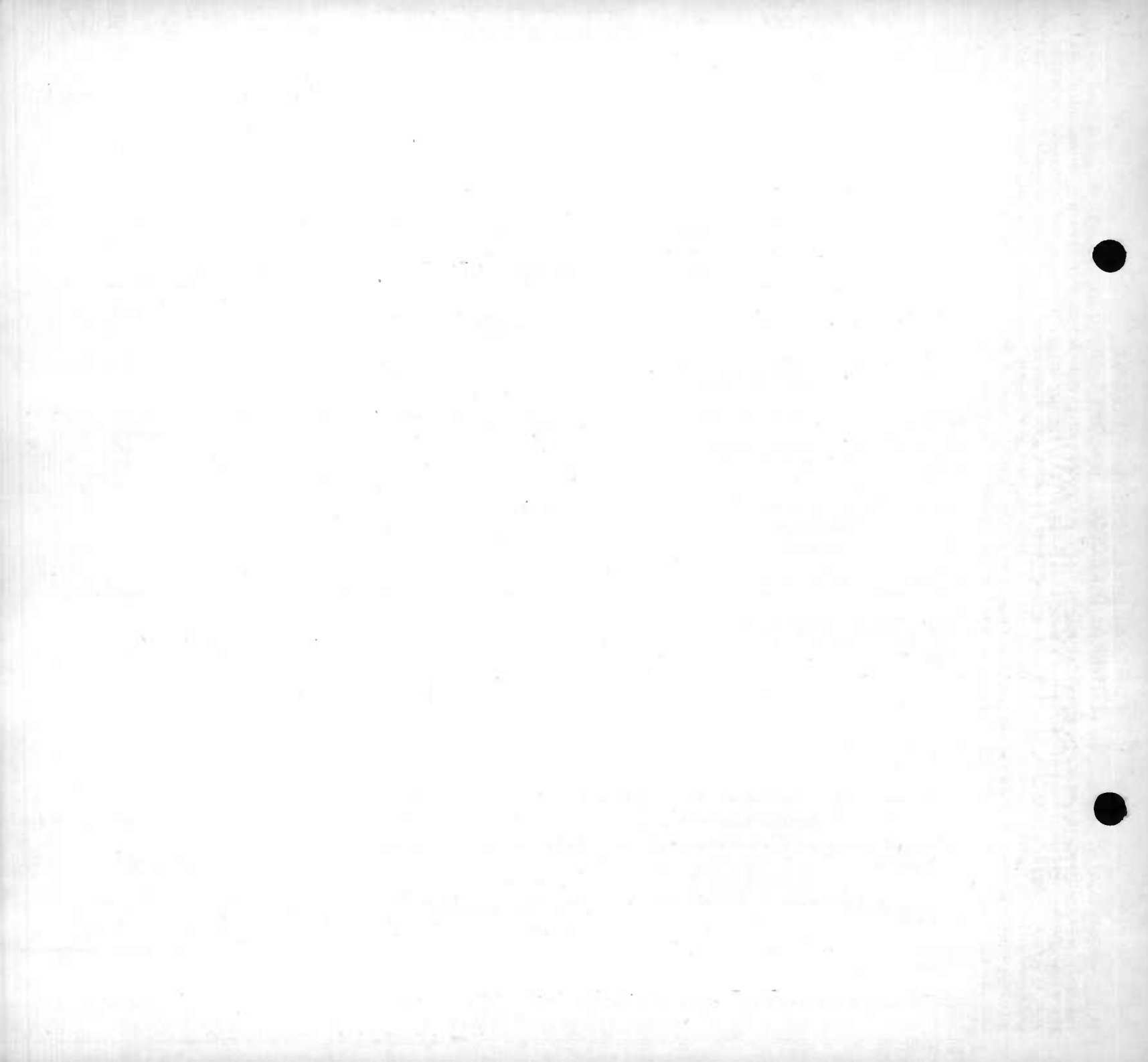
BIRTH NO. 65-01900		65 2866		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2866	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby Ben Fargason				2. DATE AND HOUR OF DEATH March 15, 1965 2:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Mercy				Maryland		Baltimore	
5. SEX m				6. RACE w.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single	
8. DATE OF BIRTH 3/14/65		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
				None		Baltimore, Maryland	
13. FATHER'S NAME Thomas Fargason				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
						Father	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) IMMATURITY DUE TO		INTERVAL BETWEEN ONSET AND DEATH Life	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/14 1965 to 3/15 1965, that (I) (we) last saw the deceased alive on 3/15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Willard E. Standiford				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/15/65	
23C. PHYSICIAN'S NAME (Type) Willard E. Standiford				23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/65		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc 5305 Harford Road.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2867		CERTIFICATE OF DEATH		Registered No. 65 2867	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				Mary Bernetta Staewen		March 14, 1965 1 3 <sup>30</sup> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY			
3010 Huron Street				Md.		2542			
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
female		white				widowed		11-16-1892	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife						Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
William Knapp				Mary Gill					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			
						William S. Staewen 4703 Sunbrook Ave.			
18. 522X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DUE TO Hypostatic pneumonia				INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO					
(C) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Rheumatoid arthritis, severe					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Feb 26 1965 to 3/13 1965, that (I) (we) last saw the deceased alive on 3/13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Herbert J. Levickas				3/15/65					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Herbert J. Levickas				5305 East Drive (21227)					
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
burial		3-17-65		Parkwood Cemetery		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAR 17 1965		Robert E. Estabrook		Leonard J. Ruck Inc		Baltimore, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>65 2868</b>		<b>CERTIFICATE OF DEATH</b>		65 2868	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>PURDUM, WILLIAM, Arthur</b>		2. DATE AND HOUR OF DEATH <b>3-14-65 7:25 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-02</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home &amp; Hospital</b>		D. STREET ADDRESS (If rural, give location) <b>3120 St. Paul St.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Separated</b>	8. DATE OF BIRTH <b>1-28-10</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>pharmacist</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Frank C. Purdum</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Berger</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-18-5806</b>		17. INFORMANT <b>Miss Dorothy Powell</b>	
18. <b>260X + 13 8/11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE PANCREATITIS</b>		CAUSE OF DEATH		ADDRESS <b>Napkins Apts. City 18</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>FATTY LIVER due to ALCOHOLISM</b>		INTERVAL BETWEEN ONSET AND DEATH	
(C) <b>DIABETES MELLITUS</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-14-65</b> to <b>3-14-65</b> that (I) (we) last saw the deceased alive on <b>3-14-65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Cesar L. Bariso</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/14/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>CESAR BARISO</b>		23D. ADDRESS M.D. <b>Church Home &amp; Hosp. Balto. 31, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/18/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 17 1965</b>		25B. NAME OF REGISTRAR <b>R. E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto Md 21214</b>	

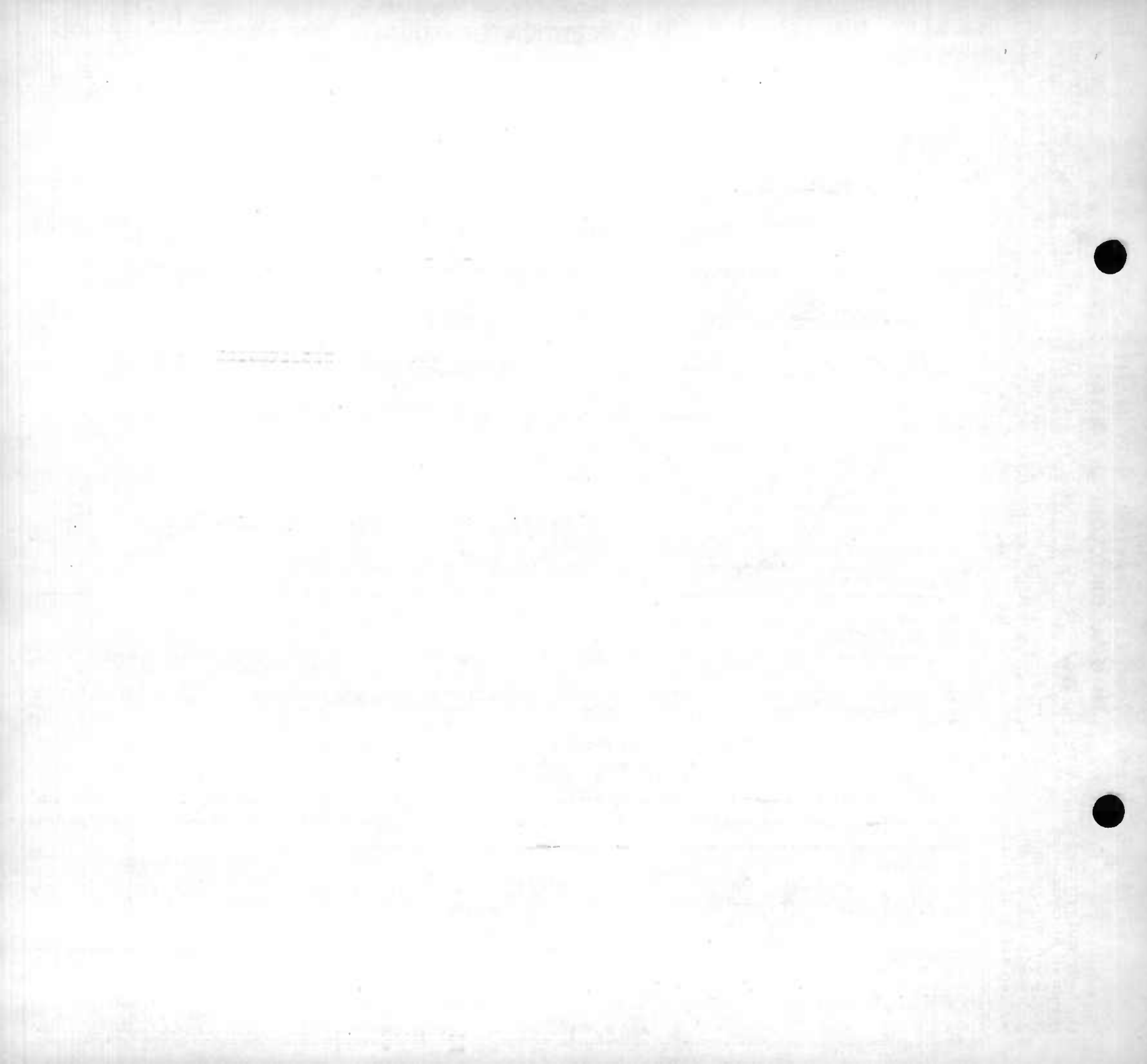


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2869</b>		Baltimore City Health Department		Registered No. <b>65 2869</b>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>Charles Dietz</b>			2. DATE AND HOUR OF DEATH <b>March 14, 1965 7:45 P. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3644 Lyndale Ave.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>26-03</b>		
5. SEX <b>male</b>			6. RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>
8. DATE OF BIRTH <b>8-15-1889</b>		9. AGE (In years last birthday) <b>75</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John Dietz</b>			14. MOTHER'S MAIDEN NAME <b>Bernadine Bochlidge</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>219742022</b>		17. INFORMANT ADDRESS <b>Catherine E. Dietz same</b>
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cardio-Vascular Hypertensive Disease</b>			<b>5 years</b>		
<b>Arteriosclerosis</b>			<b>5 years</b>		
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>January 8 1965</b> to <b>March 14 1965</b> , that (I) (we) last saw the deceased alive on <b>March 13 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Michael J. Dausch</b>				23B. DATE SIGNED <b>3/15/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Michael J. Dausch</b>				23D. ADDRESS <b>4636 Belair Road</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>#/18/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart of Jesus Cem. Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 17 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc Baltimore, Md.</b>	





# FUNERAL DIRECTOR: IMPORTANT

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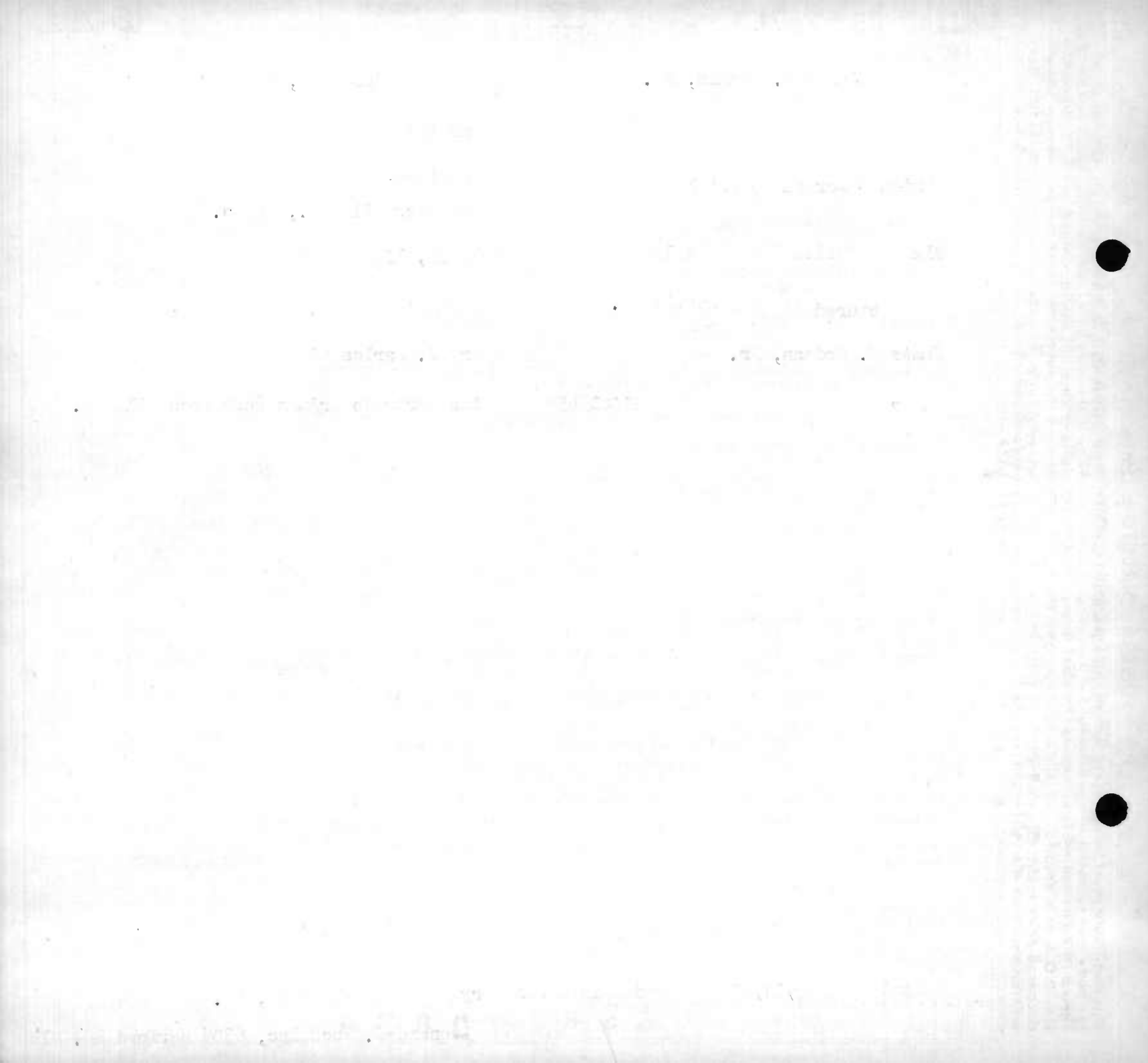
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2870		CERTIFICATE OF DEATH		Registered No. 65 2870	
M.E. CASE NO.				1. NAME OF DECEASED (Type at Print) <i>Milton Werner</i>		2. DATE AND HOUR OF DEATH <i>March 15, 1965</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>12-01</i>		5. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give sheet address or location) <i>3900 North Charles Street</i>				D. STREET ADDRESS (If rural, give location) <i>3900 North Charles Street</i>					
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>separated</i>	8. DATE OF BIRTH <i>10-2-1905</i>	9. AGE (In years last birthday) <i>59</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Classified Advertising Mgr. (Newspaper)</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Henry Werner</i>			14. MOTHER'S MAIDEN NAME <i>Bertha Lembek</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Delores Budyak, Milwaukee, Wis.</i>			ADDRESS	
18. <i>163X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Carcinoma of the lung</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>Approx. 3 mos.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <del>(the physician)</del> attended the deceased from <i>September 10</i> 19 <i>64</i> to <i>March 15</i> 19 <i>65</i> , that (I) <del>(the)</del> last saw the deceased alive on <i>March 15</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.									
23A. SIGNATURE <i>Samuel Whitehouse</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3/15/65</i>			
23C. PHYSICIAN'S NAME (Type) <i>Samuel Whitehouse</i>				23D. ADDRESS M.D. <i>3900 North Charles Street</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>3-18-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Graceland Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Milwaukee, Wisconsin</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 17 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Jankowski</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i>					



# FUNERAL DIRECTOR: IMPORTANT

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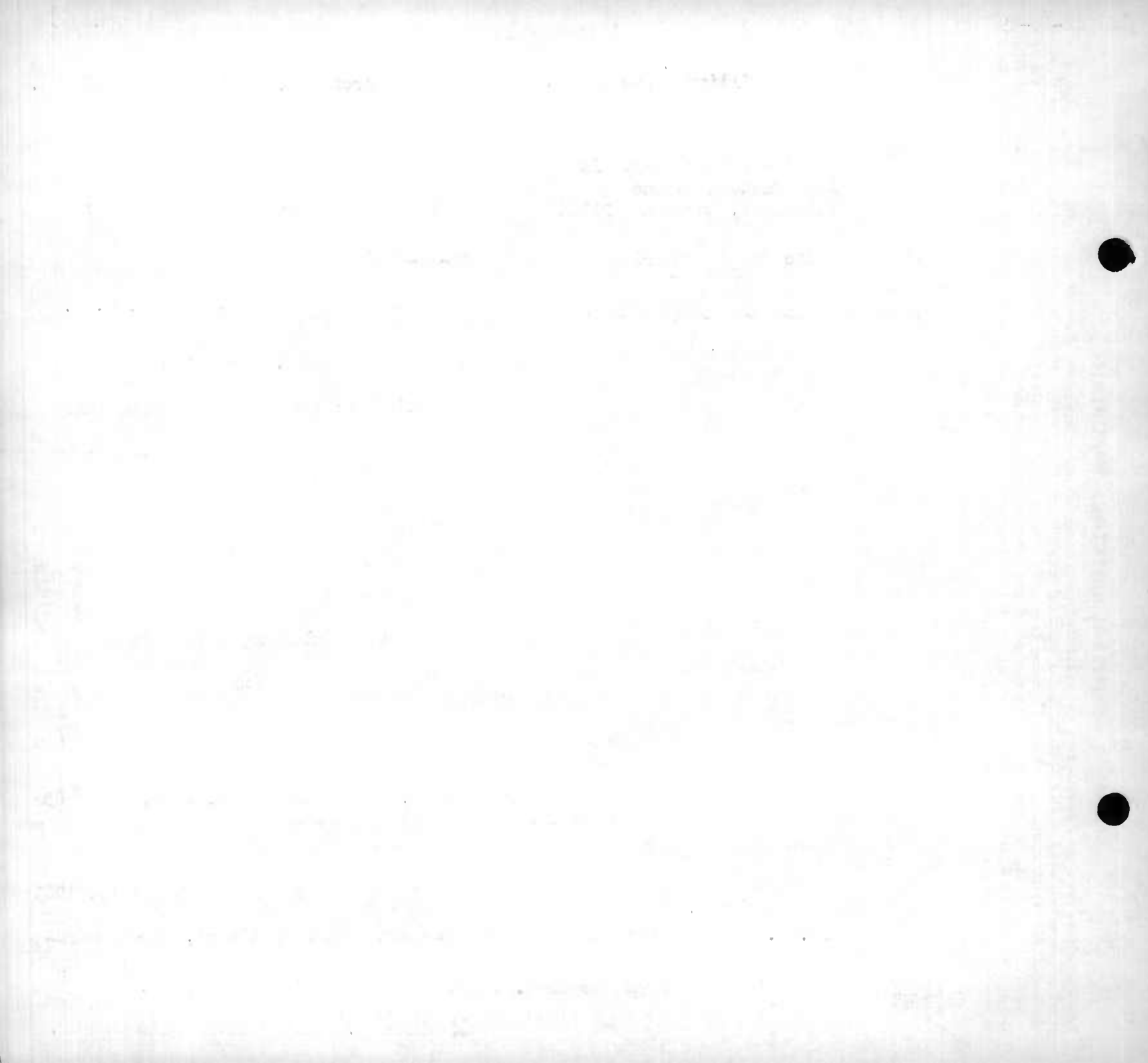
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 2871					CERTIFICATE OF DEATH					Registered No. 65 2871				
1. NAME OF DECEASED (Type or Print) <b>James M. Erdman, Jr.</b>										2. DATE AND HOUR OF DEATH <b>March 14, 1965</b> <b>7<sup>00</sup> P. M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>										4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>6686 Loch Hill Rd., Balto. 12</b>				
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>		8. DATE OF BIRTH <b>July 21, 1905</b>		9. AGE (In years last birthday) <b>59</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retured</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Martin Co.</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>James M. Erdman, Sr.</b>						14. MOTHER'S MAIDEN NAME <b>Mary J. Carlos</b>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213015459</b>		17. INFORMANT ADDRESS <b>Miss Gertrude Erdman 6686 Loch Hill Rd.</b>								
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Coronary Occlusion</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>arterio-sclerotic</b> <b>cardio-vascular disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 yrs.</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <b>6</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 10 - 1960</b> to <b>Mar 14</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Mar 2</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <b>George Sawyer</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>								23B. DATE SIGNED <b>3/16/65</b>						
23C. PHYSICIAN'S NAME (Type) <b>GEORGE SAWYER, M.D.</b>						23D. ADDRESS <b>4808 Harford Rd. - Balto 14 Ind.</b>								
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>3/17/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 17 1965</b>				25B. NAME OF REGISTRAR <b>Robert J. Sawyer</b>				25C. FUNERAL DIRECTOR <b>Leonard J. Buck Inc., 5305 Harford Rd. #11</b>						



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2872</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2872</b>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>William Shawgo Sr.</b>			2. DATE AND HOUR OF DEATH <b>March 15, 1965 5:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3221 Berkshire Road 21214</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10-23-1890</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Checker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Food Whse.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>William Shawgo</b>		
14. MOTHER'S MAIDEN NAME <b>Anna Groom</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>RECORDS: BCH: 4940 Eastern Avenue #24</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Lung Cancer</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Old Inactive Pulmonary Tuberculosis</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 19, 1964</b> to <b>March 15, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 15, 1965</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. C. Robert Cooke</b>			23B. DATE SIGNED <b>March 15, 1965</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. C. Robert Cooke</b>			23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland #24</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/18/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Moreland Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 17 1965</b>			
25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Balto 14 Md.</b>			





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65 2873

BALTIMORE CITY HEALTH DEPARTMENT

65 2873

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH E. GREUL

2. DATE AND HOUR PRONOUNCED DEAD

March 14, 1965 3:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE CORRECTED

3-22-65

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1745 N. Milton Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

1891

9. AGE (in years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Ret. Fireman

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City F.D.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Greul

14. MOTHER'S MAIDEN NAME

Rosa Kienle

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-22-1194

17. INFORMANT

ADDRESS

Mrs. Dorothy A. Reilly 1309 Ballard Way #24

18. 422-18265X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Peter W. Rieckert, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

3-15-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/18/65.

23C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 17 1965

Robert E. Taylor

Leonard J. Buck Inc. Balto 14 Md.

Birth Cert. A-32512 - 1891  
3-22-65 M.H.

VALLEY FORCE

RAC CONTENT

U.S.A.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2874		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2874	
M.E. CASE NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) CHESTER O STONE		2. DATE AND HOUR OF DEATH 3 14 65   2:05 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE			
		D. STREET ADDRESS (If rural, give location) 200 3RD AVE., S W			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5 31 15	9. AGE (In years lost birthday) 49	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MARKET OWNER		10B. KIND OF BUSINESS OR INDUSTRY MEAT MARKET		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Albert Lee Stone		14. MOTHER'S MAIDEN NAME Carrie Wheeler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-18-2261		17. INFORMANT ST AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Acute myocardial Infarction followed by cardiac arrest. (B) DUE TO Acute renal failure. (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3 11 19 65 to 3 14 19 65, that (I) (we) last saw the deceased alive on 3 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/14/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-18-65		24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION (City, town, or county) (State) Ritchie Hwy. Arundel Co. Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 17 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Flynn & Fleming, 1422 Light St. Balto. Md.					

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made. Medical examiner notified and approved removal per Sister Marie, Mercy Hospital 3/15/65-180

BIRTH NO. 65 2875		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2875	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) MARY ESTHER DONNELLY		2. DATE AND HOUR OF DEATH 3-14-65 1:21 PM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL BALTIMORE, MD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY See below Montgomery C. CITY OR TOWN (If outside city limits, write RURAL and give township) Takoma Park, Md. 65-00 D. STREET ADDRESS (If rural, give location) 913 Domer Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10/1/1879	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Retired)		10B. KIND OF BUSINESS OR INDUSTRY Pharmaceutical Co.		11. BIRTHPLACE (State or foreign country) Alexandria, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Stenographer Seymour Stoutenburgh		14. MOTHER'S MAIDEN NAME Anna Morrow	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 220-44-6927		17. INFORMANT Mrs. Mary A. Hughes 913 Domer Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19. CAUSE OF DEATH RIGHT UPPER LOBE PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 10 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JAN -3- 19 65 to MARCH 14 19 65 that (I) (we) last saw the deceased alive on 3-14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Motorangelo		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-14-1965	
23C. PHYSICIAN'S NAME (Type) Joseph Motorangelo, Mercy Hosp.		M.D. 23D. ADDRESS Mercy Hospital, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/17/65		24C. NAME OF CEMETERY or CREMATORY Arlington National	
24D. LOCATION (City, town, or county) Arlington		(State) Virginia			
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1965		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Margaret E. Pumpfrey	
25D. ADDRESS 8434 Glenora Ave					

Pending approval of medical exam. office

General 3/12 (Lington) Virginia  
Morgan's Cavalry



# FUNERAL DIRECTOR: IMPORTANT

To be approved by Medical Examiner

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 2876	
BIRTH NO. 65 2876		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William E. Fillingame		2. DATE AND HOUR OF DEATH 3/14/65 8:20 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 13-08	
UNION MEMORIAL Hospital		C. CITY OR TOWN BALTIMORE		D. STREET ADDRESS (If rural, give location) 1503 Union Avenue	
6. SEX M	7. RACE W	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	9. DATE OF BIRTH 4/21/12	10. AGE (In years last birthday) 52	11. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Mississippi	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alcus Fillingame		14. MOTHER'S MAIDEN NAME Mollie Randall	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1934-1937		16. SOCIAL SECURITY NO. 426-16-9115		17. INFORMANT Elsie L. Fillingame 1503 Union Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		19. CAUSE OF DEATH 2° + 3° Burns of Body		INTERVAL BETWEEN ONSET AND DEATH 10 days	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 13/3/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BURNS		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1503 Union Avenue 13-08	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 3 3 65		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Trying to ignite stove & Alcohol	
22. I certify that (H) (this hospital) attended the deceased from 3/3 1965 to 3/14 1965, that (W) (we) lost saw the deceased alive on 3/14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William N. Bennett M.D.				23B. DATE SIGNED 3/14/65	
23C. PHYSICIAN'S NAME (Type) William N. BENNETT M.D.				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-19-65		24C. NAME OF CEMETERY or CREMATORY Evergreen Cemetery Gulfport, Mississippi	
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Burge Funeral Home 3631 Falls Rd	



1934-1937

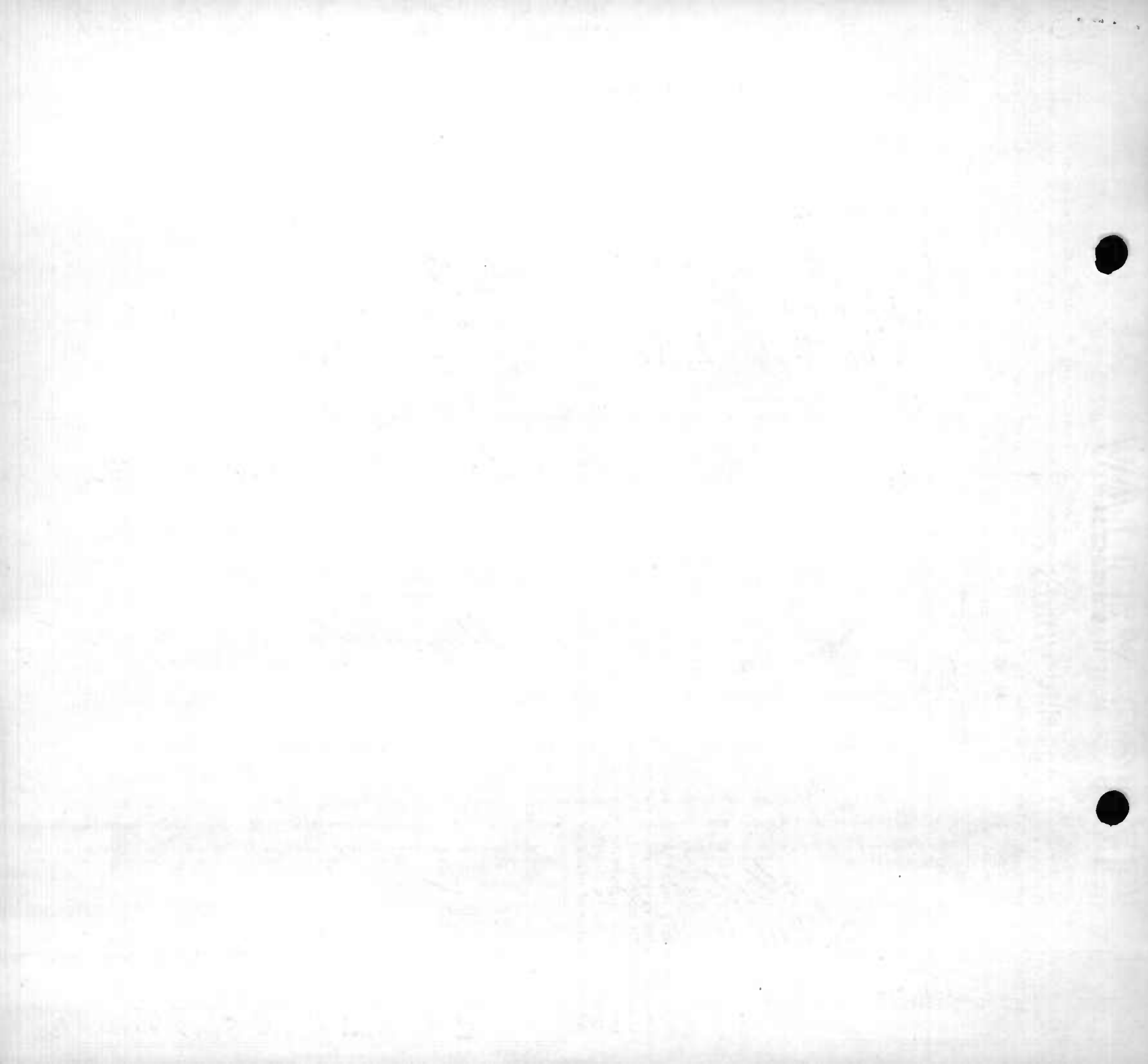
DEPARTMENT OF AGRICULTURE

W

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2877				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2877	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BESSIE R. STONE</b>				2. DATE AND HOUR OF DEATH <b>MARCH 14 1965</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEM. Hosp.</b>				A. STATE <b>MD</b> B. COUNTY <b>Balto</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto</b>			
				D. STREET ADDRESS (If rural, give location) <b>2800 MAPLE AVE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOW</b>		8. DATE OF BIRTH <b>DEC 29 1883</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NOT HOME</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CANADA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHRISTOPHER L. REW</b>				14. MOTHER'S MAIDEN NAME <b>SARAH CLAIR</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>FAMILY RECORDS</b>		ADDRESS	
18. <b>422.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Anterior infarctus CVDisease</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>12yrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>Malnutrition</b>		<b>6mrs</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>S. Elliott Harris</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>S. ELLIOTT HARRIS</b>				23D. ADDRESS <b>8100 HARTFORD RD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-17-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Dulaney Valley Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Co MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 17 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Stalder</b>		25C. FUNERAL DIRECTOR <b>CELESTINE</b>		25D. ADDRESS <b>1 SON 8802 HARTFORD RD</b>	

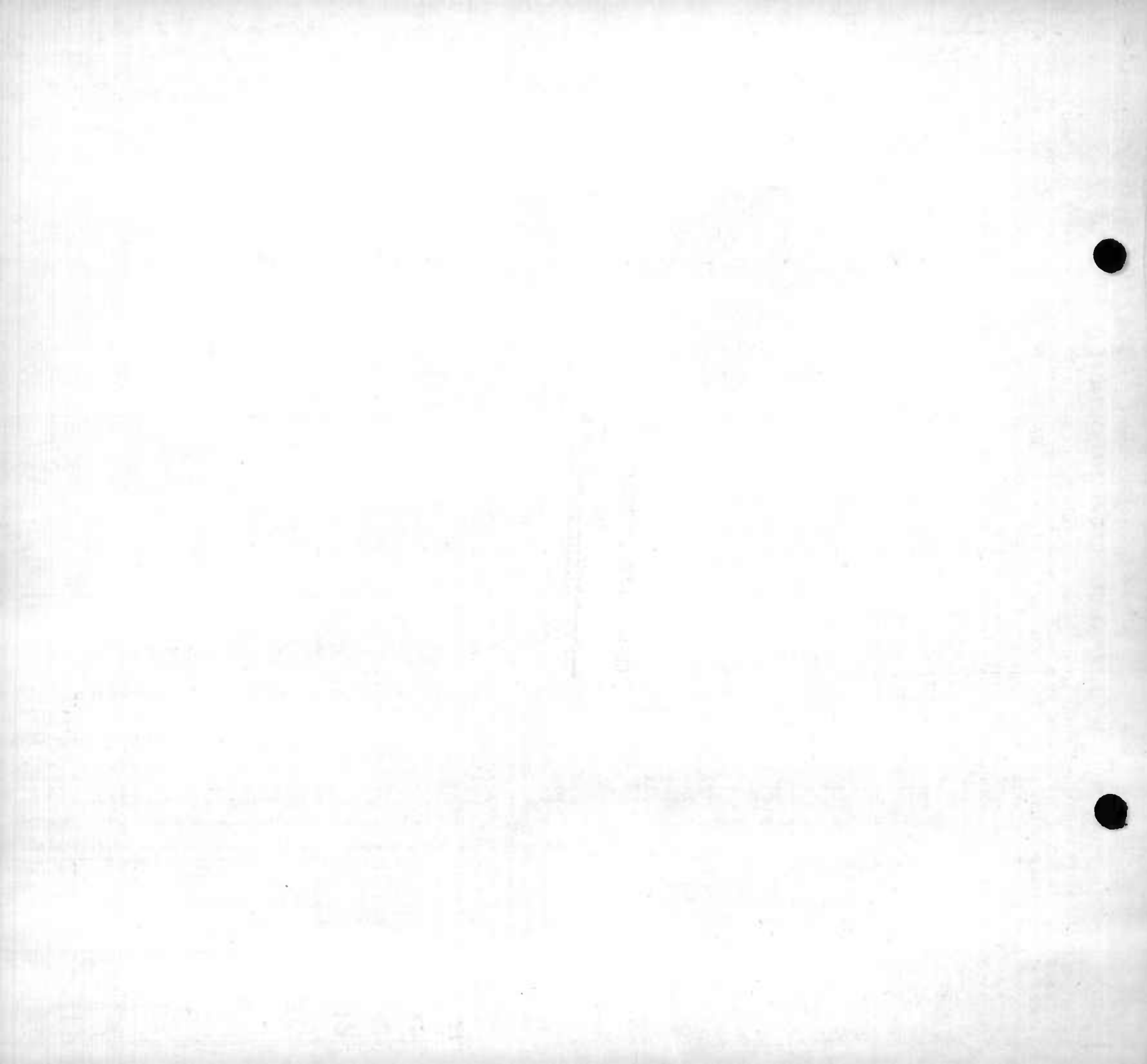


For approval by medical examiner 3, 2, 010

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

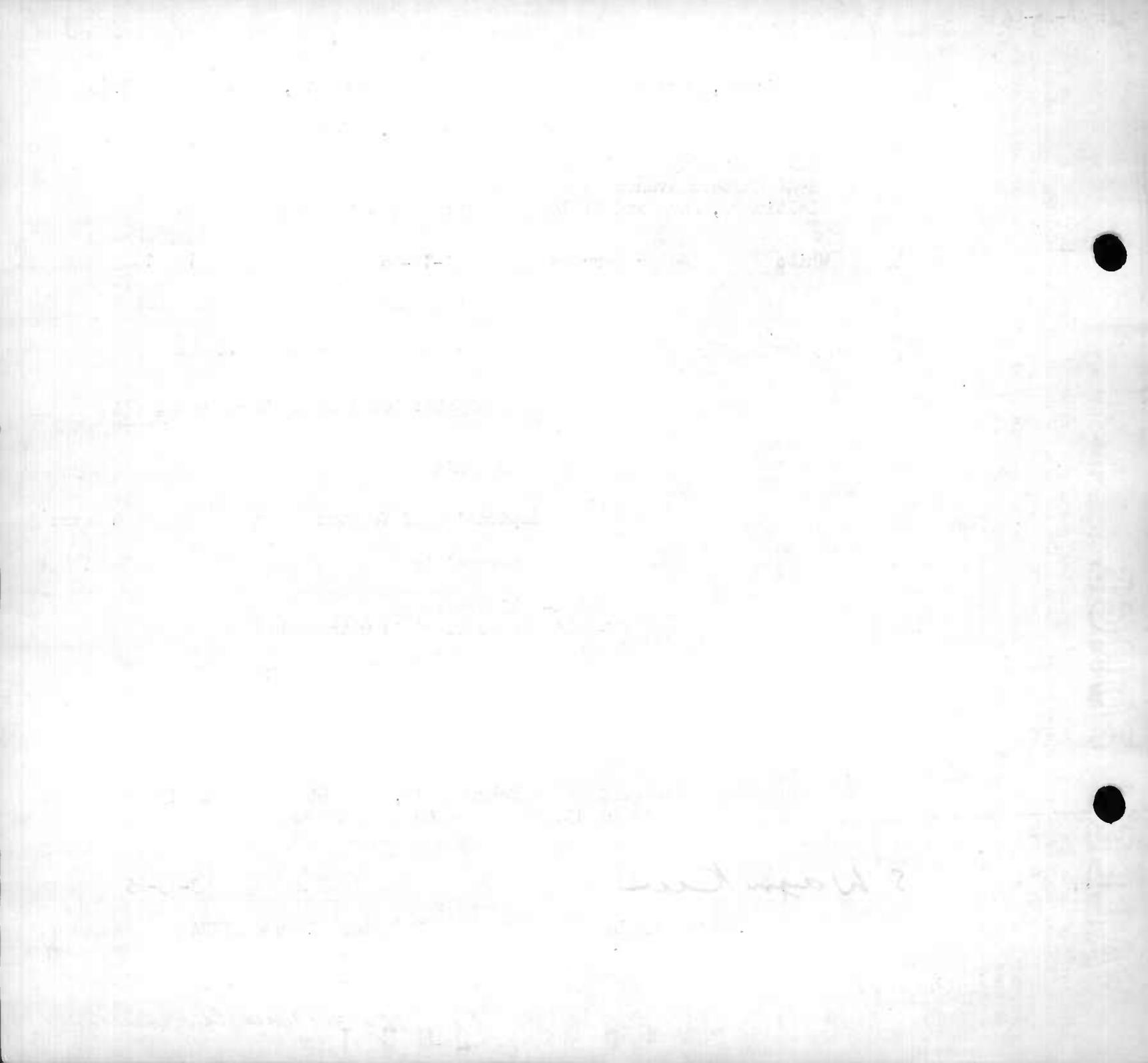
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2878	
BIRTH NO. 65 2878					
CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		Harry I. Bass		3/14/65 10 <sup>45</sup> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
Md. General Hosp.				Md. 13-02	
Linden Ave. Balto, Md.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				D. STREET ADDRESS (If rural, give location)	
				2236 Linden Ave.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)
M	W			2/2/86	79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Window DRESSER				EUROPE	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Morris Bass				Sarah EcheKson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		25-09-5213		WIFE	
18. 370.21		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		GANGRENE of Colon 6 hr.		12 hr.	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		M. D. 3/14/65			
ANTECEDENT CAUSES		M. D. 3/14/65			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		M. D. 3/14/65			
II		M. D. 3/14/65			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		M. D. 3/14/65			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
13/14/65		See above		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3/14 1965 to 3/14 1965, that (I) (we) last saw the deceased alive on 3/14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Leonard W. Glass				3/14/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Leonard W. Glass				Md. General Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		3-16-65		BETH HEMADOTH HAGBOL ROSEDALE Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 17 1965		R. E. Stuber, M.D.		Paul J. Harris Inc 2100 Eutaw Pl	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2879</u>	
BIRTH NO. <u>65 2879</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Fritsch, Marcia</u>		2. DATE AND HOUR OF DEATH <u>March 13, 1965</u>   <u>7:55</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland, Baltimore</u> B. COUNTY <u>Balto</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>53-00</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		D. STREET ADDRESS (If rural, give location) <u>4040 Riverside Road</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>1-25-65</u>	9. AGE (In years last birthday) <u>1</u> <u>16</u>	If Under 1 Yr. Months: Days: Hours: Min. <u>1</u> <u>16</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Henry Fritsch</u>			14. MOTHER'S MAIDEN NAME <u>Mabel Schrieffer</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>RECORDS: BCH 4940 Eastern Avenue #24</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>492X I</u> <u>Asphyxia</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>Asphyxia</u> DUE TO			
		(B) <u>Aspiration of Vomitus</u> DUE TO		<u>6 hours</u>	
		(C) <u>Pneumonitis</u>		<u>?</u>	
II		Post E-Coli Sepsis E-Coli Gastroenteritis with marked inanimationsugar intolerance			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>February 13, 1965</u> to <u>March 13, 1965</u> , that (I) (we) last saw the deceased alive on <u>March 13, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S Wayne Klein</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <u>3-13-65</u>		
23C. PHYSICIAN'S NAME (Type) <u>S. Wayne Klein</u>		M.D.	23D. ADDRESS <u>4940 Eastern Avenue 21224</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE	24C. NAME OF CEMETERY or CREMATORY <u>Mt. Carmel</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 17 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Connelly 300 Race Ave. Balto. 21</u>	

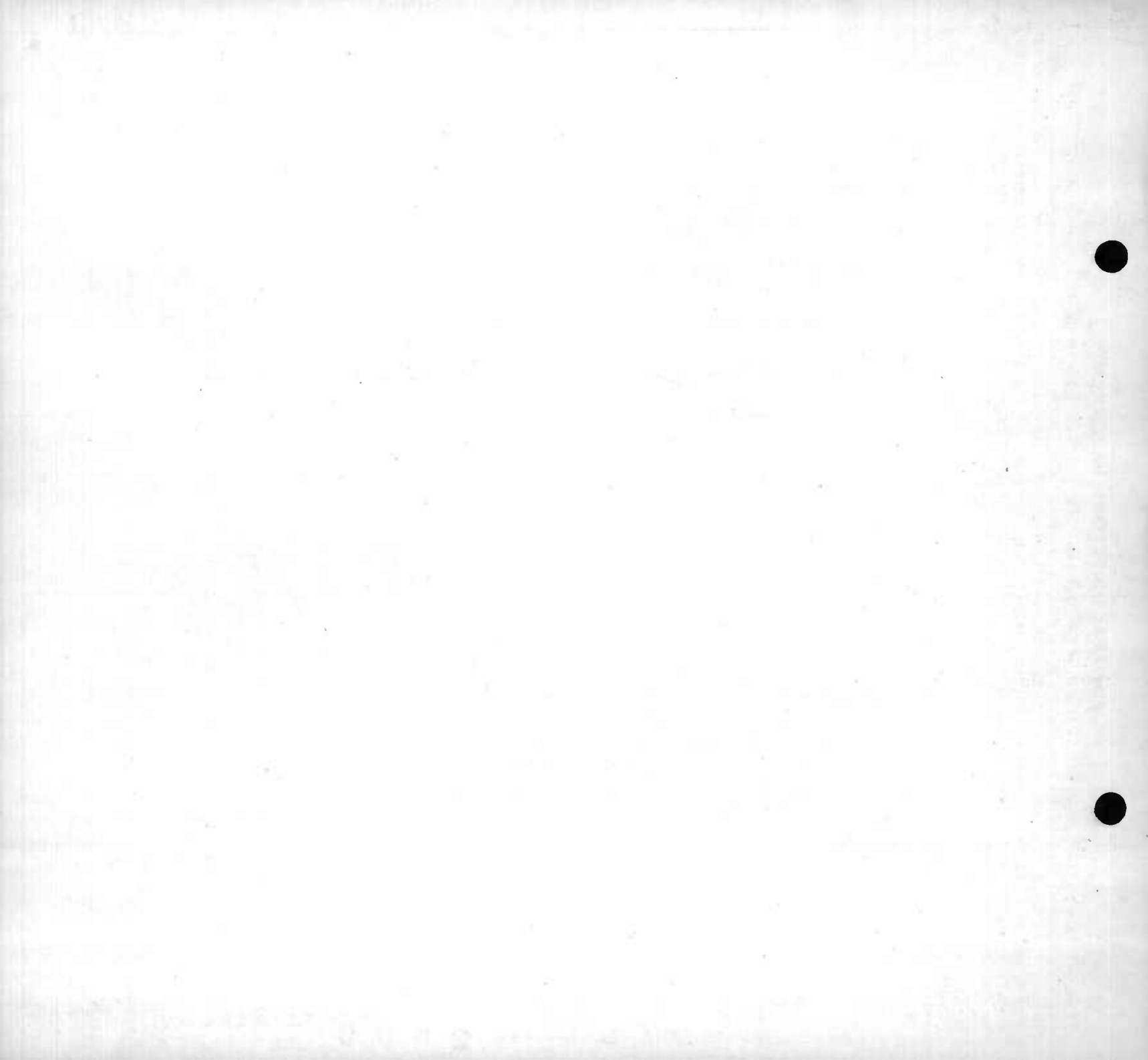




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

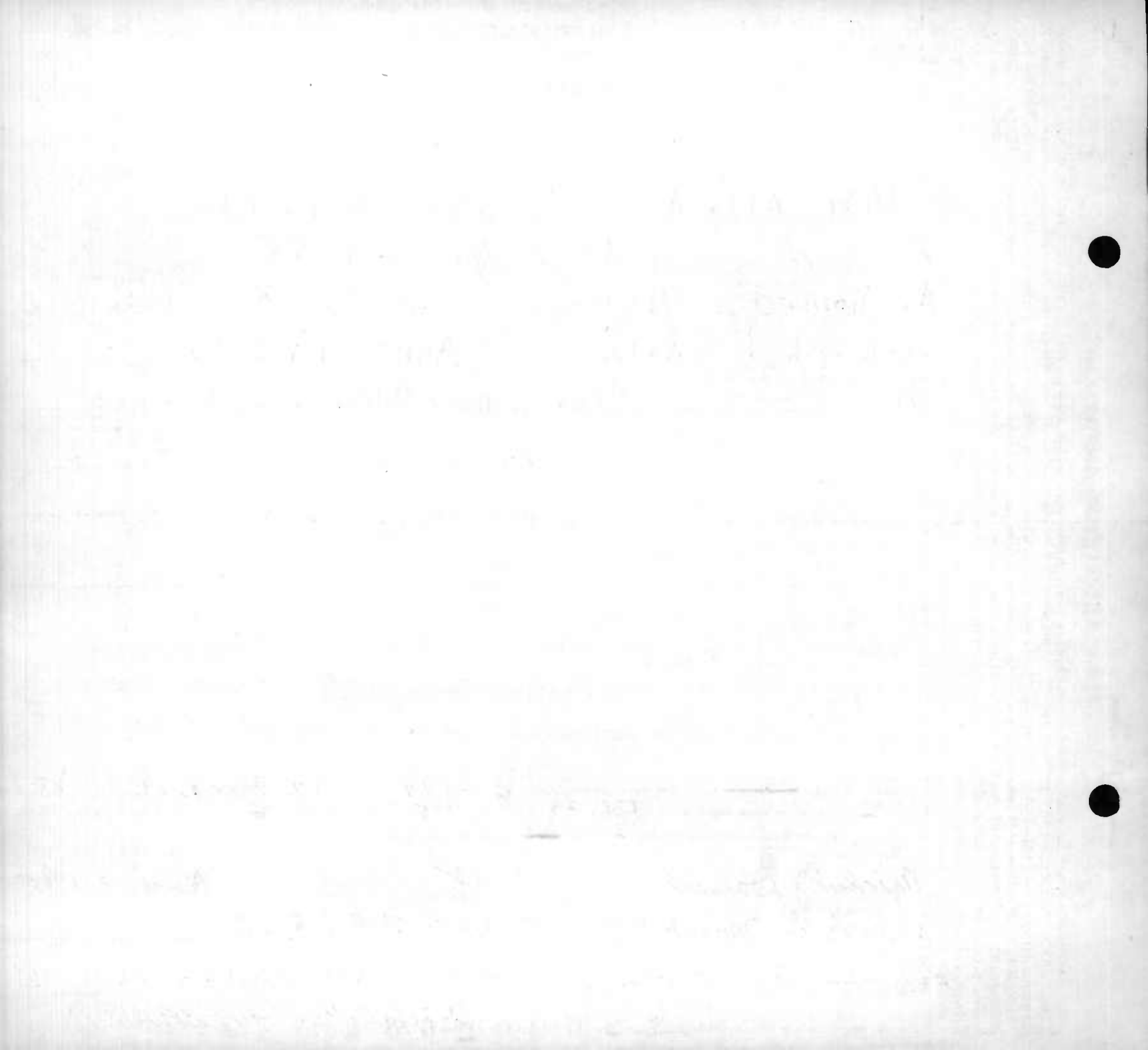
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2880</b>	
BIRTH NO. <b>65 05216</b> <b>65 2880</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>3-12-65 8.30</b>	
1. NAME OF DECEASED (Type or Print) <b>DIANE LYNN SITES</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>		A. STATE <b>MD</b> B. COUNTY <b>BALTO</b>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 5300</b>	
		D. STREET ADDRESS (If rural, give location) <b>3314 Grace Rd. #19</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>-</b>	8. DATE OF BIRTH <b>3-8-65</b>
		9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Grover SITES</b>		14. MOTHER'S MAIDEN NAME <b>Doris Irving</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Information from Chart.</b>
18. <b>754.571</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Septicemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days -</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Conjunctive Death Disease</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)	
MEDICAL CERTIFICATION			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>-</b>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>3-12-65 (12.30 PM)</b> to <b>3-12-65 (8.30 PM)</b> , that (I) (we) last saw the deceased alive on <b>3-12-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Carlo Abel</b>		23B. DATE SIGNED <b>3-12-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARLO ABEL</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/16/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Balto. National</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 17 1965</b>	25B. NAME OF REGISTRAR <b>John E. Starkey M.D.</b>	25C. FUNERAL DIRECTOR ADDRESS <b>300 Mace Ave. Balto. 21</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2881	
BIRTH NO. 65 2881		CERTIFICATE OF DEATH		Registered No. 65 2881	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Anna K. Zoinlan		2. DATE AND HOUR OF DEATH March 15-65 5:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. STATE Md. 6. COUNTY 27-05	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.	
6421 Alta Ave		D. STREET ADDRESS (If rural, give location)		6421 Alta Ave	
5. SEX F.	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Nov. 11 1879	9. AGE (In years last birthday) 85	10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Koskarn		14. MOTHER'S MAIDEN NAME Anna Preller	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Marie Meltzer 6421 Alta Ave	
18. 187.0 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Toxic Absorption		7 hours	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(B) Carcinoma of Bladder		3 years	
ANTECEDENT CAUSES		(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from July 19 1962 to March 15 1965, that (I) (we) last saw the deceased alive on Feb. 23, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Michael J. Dausch M.D.		23B. DATE SIGNED March 15, 1965	
23C. PHYSICIAN'S NAME (Type) Michael J. DAUSCH		23D. ADDRESS M.D. 4636 Belair Road			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/17/65		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER	
24D. LOCATION 4460 BELAIR RD BALTO. MD		25A. DATE REC'D BY HEALTH DEPT. MAR 17 1965		25B. NAME OF REGISTRAR Robert E. Stokely	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. 7110 BELAIR RD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>a a. Co., Md. 65</i>		2882		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <i>65 2882</i>	
M.E. CASE NO.				X			
1. NAME OF DECEASED (Type or Print) <b>MARK HAMRICK.</b>				2. DATE AND HOUR OF DEATH <b>3-15-65 8,30 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>GAMBRILL 5200</b> D. STREET ADDRESS (If rural, give location) <b>U.S. NAVAL ACADEMY DAIRY</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>CHILD</b>	8. DATE OF BIRTH <b>2-15-65</b>	9. AGE (In years last birthday) <b>1 MONTH</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>A.A. Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>BENJAMIN HAMRICK</b>				14. MOTHER'S MAIDEN NAME <b>HELEN LASTER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>MR. BENJAMIN HAMRICK #4</b>		ADDRESS	
18. <b>757.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Renal Dysplasia</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <b>Electrolyte Imbalance 2wks</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2/15/65 - 3/15/65 (1 mo)</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>3/12/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Uterine obstruction</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/15 3/5 19 65</b> to <b>3/15 19 65</b> , that (I) (we) last saw the deceased alive on <b>3/15 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>B.W. Nilson</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/15</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. B. W. NILSON</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL JHH CMSC</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/18/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>HILLCREST CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>ANNAPOLIS MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 17 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Robert E. Taylor</b>		ADDRESS <b>ANNAPOLIS MD.</b>	

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65 2883

BALTIMORE CITY HEALTH DEPARTMENT

65 2883

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) LOUISE E. WOLFE 2. DATE AND HOUR PRONOUNCED DEAD March 16, 1965 5:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location)

UNION MEMORIAL HOSPITAL Baltimore 21218 2646 Maryland Avenue

5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married 8. DATE OF BIRTH July 12, 1921 9. AGE (In years lost birthday) 43 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Harry Shover 14. MOTHER'S MAIDEN NAME Agnes Gilmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 229-18-2399 17. INFORMANT ADDRESS 18

Lacy S. Wolfe. 2646 Maryland Avenue, Baltimore

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Lobar pneumonia

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fatty metamorphosis of liver

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE John E. Adams, M.D. CHIEF MEDICAL EXAMINER DATE SIGNED 3-16-65

EXAMINER'S NAME (Type) John E. Adams, M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

23A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL 23B. DATE 3-17-65 23C. NAME OF CEMETERY OR CREMATORY Thornrose Cemetery 23D. LOCATION (City, town, or county) Staunton, Virginia

24A. DATE REC'D BY HEALTH DEPT. MAR 17 1965 24B. NAME OF REGISTRAR Robert E. Farber 24C. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street, Baltimore

VS 151-REV. 1/1/65



VALLEY FORD

RAILROAD

*John E. Allen*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

65 2884

BIRTH NO.

65 2884

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

(Doe) THEODORE T. MARTIN

2. DATE AND HOUR OF DEATH

MARCH 14, 1965 5:18 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND (BALTIMORE COUNTY)

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

405-GEORGIA-COURT BALTIMORE

D. STREET ADDRESS (If rural, give location)

405 GEORGIA COURT

5. SEX

FEMALE WHITE

6. RACE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

July 2, 1894

9. AGE (In years last birthday)

70

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Mississippi

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Benjamin Archer Tucker

14. MOTHER'S MAIDEN NAME

Maggie Ward

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Family records

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

acute myocardial infarction

(B) DUE TO

(C)

48 hours

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work

Not While At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/13 1965 to 3/14 1965, that (I) (we) lost saw the deceased alive on 3/14 1965 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

M.E. Raichle

M.D.

Attending Phys.

Med. Director

Staff Phys.

23B. DATE SIGNED

3/14/65

23C. PHYSICIAN'S NAME (Type)

M.E. Raichle

23D. ADDRESS

M.D.

John Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Mar. 17, 1965

24C. NAME of CEMETERY or CREMATORY

Druid Ridge Cemetery

24D. LOCATION

(City, town, or county)

(State)

Pikesville, Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAR 17 1965

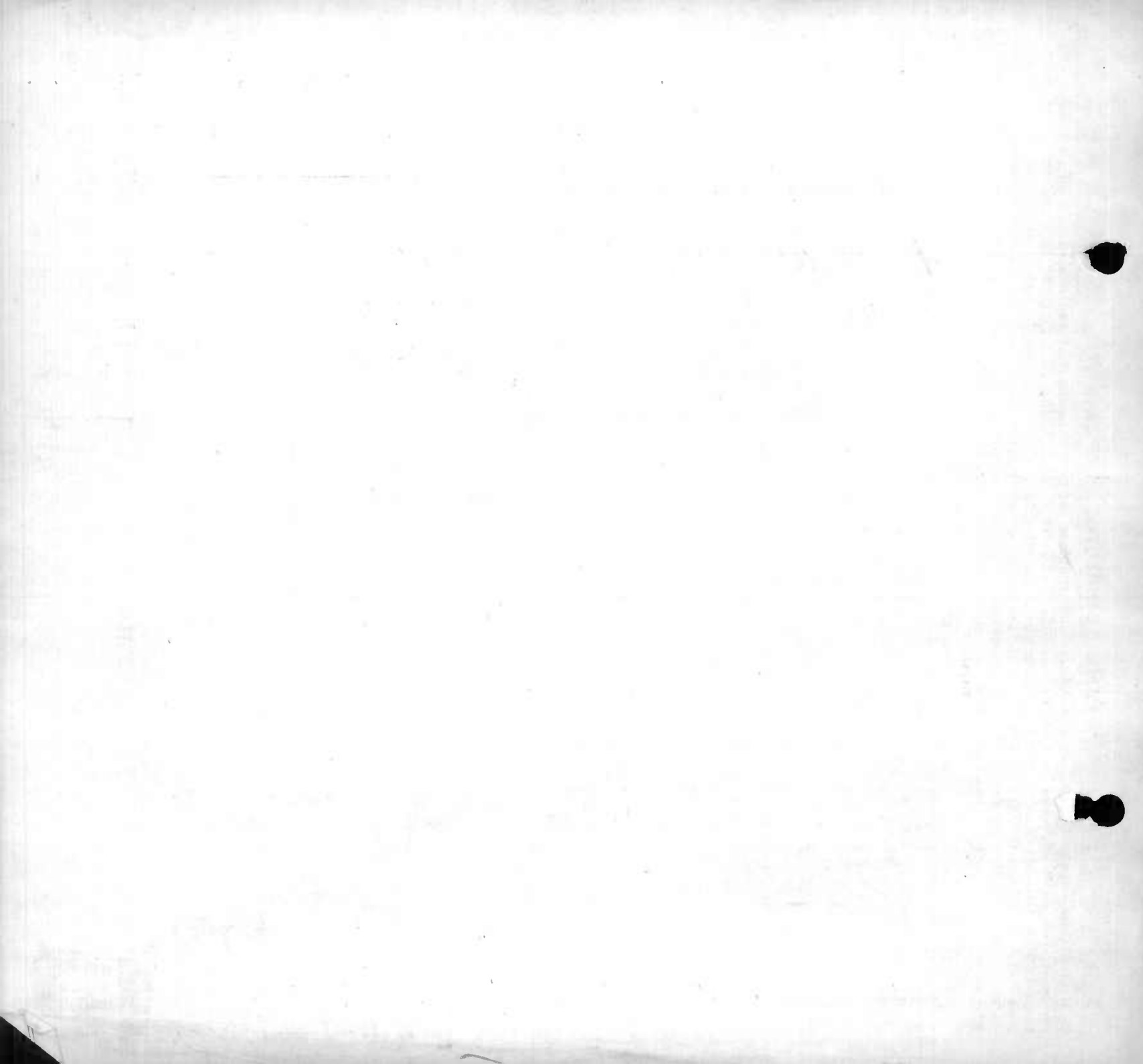
25B. NAME OF REGISTRAR

Robert E. ...

25C. FUNERAL DIRECTOR

John ... Sons, Towson, Maryland

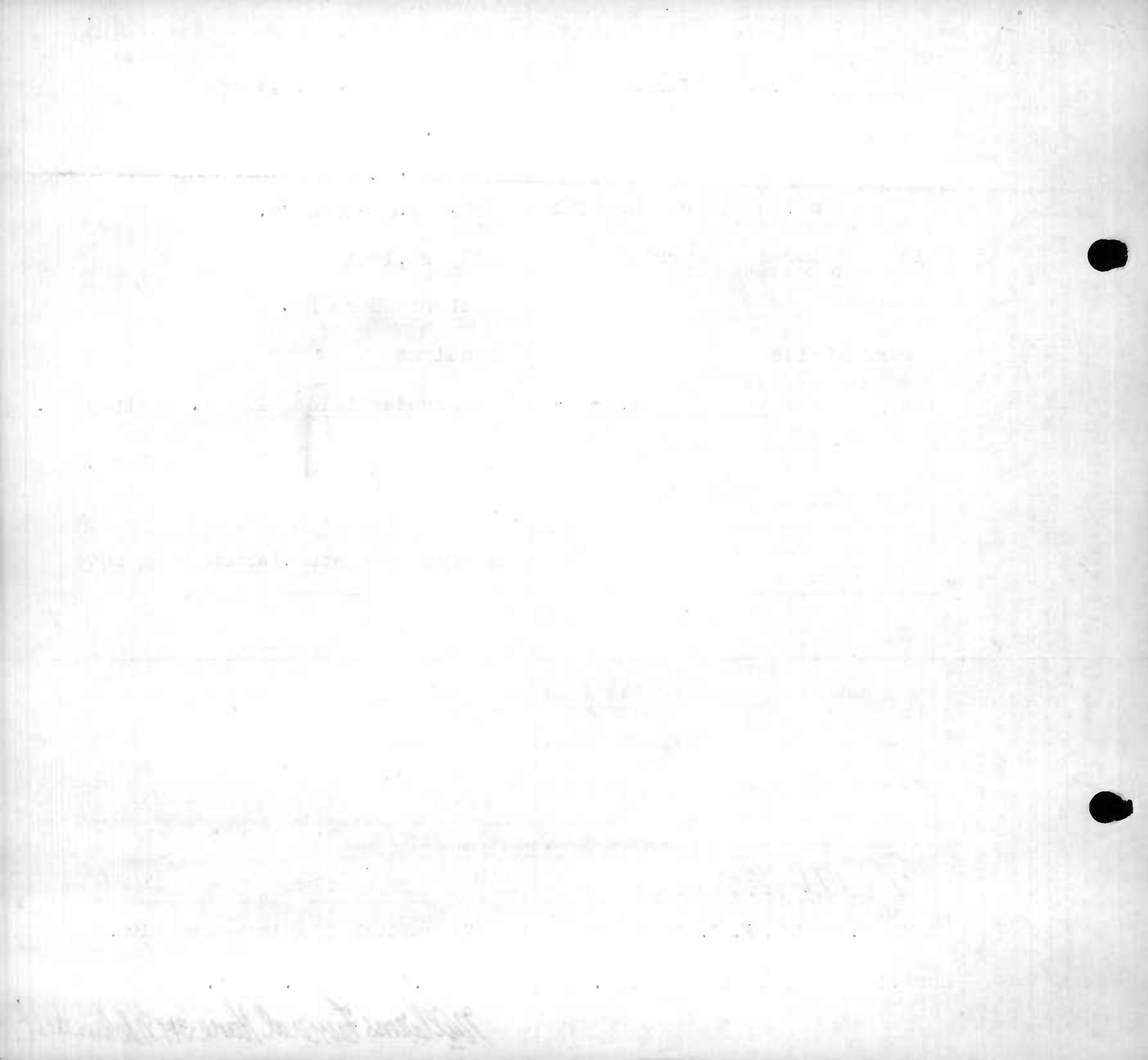
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

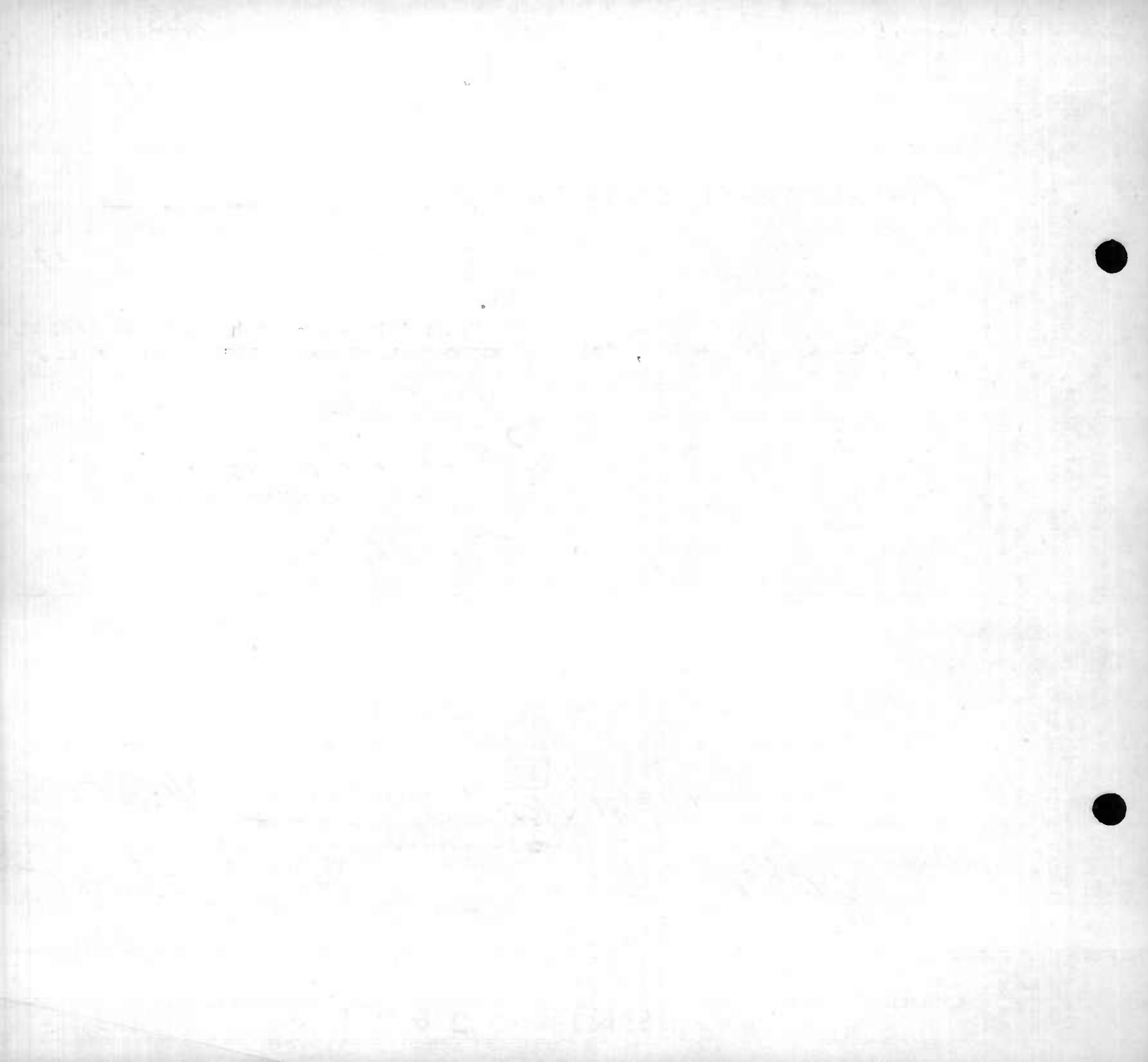
BIRTH NO. 65 2885				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2885	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ARTHUR FIELDS</b>				2. DATE AND HOUR OF DEATH <b>MARCH 14, 1965</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Franklin Square Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>18-02</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto.</b>			
				D. STREET ADDRESS (If rural, give location) <b>229 N. Carlton St.</b>			
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		B. DATE OF BIRTH <b>July 23, 1901</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Eastern Shore Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frank Fields</b>				14. MOTHER'S MAIDEN NAME <b>Madeline</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes W W 1</b>		16. SOCIAL SECURITY NO. <b>218-07-2126</b>		17. INFORMANT <b>Gertrude Fields</b>		ADDRESS <b>229 N. Carlton St.</b>	
18. <b>163XX-1002-2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Carcinoma of the lung</b> DUE TO (B) DUE TO (C) <b>Pulmonary tuberculosis inactive since 1957</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <b>12/7/64</b> 19 to <b>2/12</b> 19 <b>65</b> , that (X) (we) lost saw the deceased alive on <b>3/10</b> 19 <b>65</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (IX) (We) (did not) view the body after death.							
23A. SIGNATURE <b>David N. Marine</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/16/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>DAVID N. MARINE, M. D.</b>				23D. ADDRESS <b>VA Hospital, 3900 Loch Raven Blvd.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/18/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Balto. National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 17 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		ADDRESS <b>319 N. Frederick St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-07247		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2886	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Wall Baby Girl</i>		2. DATE AND HOUR OF DEATH <i>3/14/65 11:20 pm</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2804</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 408 Rock GLEN. Rd</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>2025 W. Baltimore St.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>---</i>	8. DATE OF BIRTH <i>3/14/65</i>	9. AGE (In years last birthday) <i>5</i>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. <i>17</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Ma.</i>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Frank P. Wall, 3rd</i>		14. MOTHER'S MAIDEN NAME <i>Helen Koch 408 Rock Glen Rd. 21229 Md.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Frank Wall Jr. 408 Rock Glen Rd</i>	
18. <i>773.5 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cardio respiratory insufficiency</i> <i>Prematurity</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/14/65</i> 19 to <i>3/14/65</i> 19, that (I) (we) last saw the deceased alive on <i>3/14/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. G. Gormley</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Sick Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/15/65</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>M.D.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <i>3/16/65</i>	24C. NAME OF CEMETERY or CREMATORY <i>Western</i>	24D. LOCATION (City, town, or county) (State) <i>Balto. 23</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 17 1965</i>	25B. NAME OF REGISTRAR <i>Robert E. Edwards</i>	25C. FUNERAL DIRECTOR <i>Edmondson</i>	ADDRESS <i>4101 Edmondson</i>		

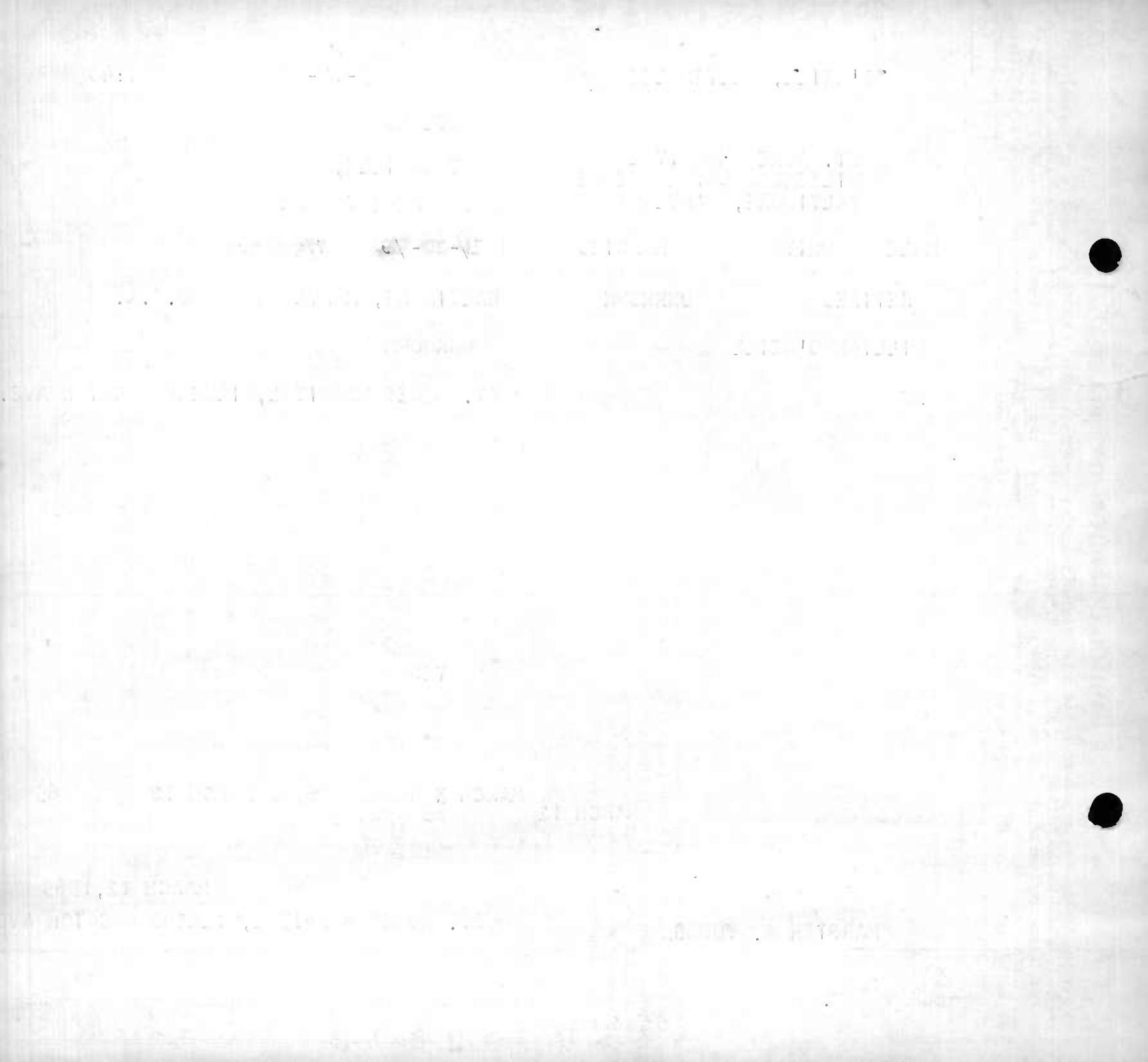




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

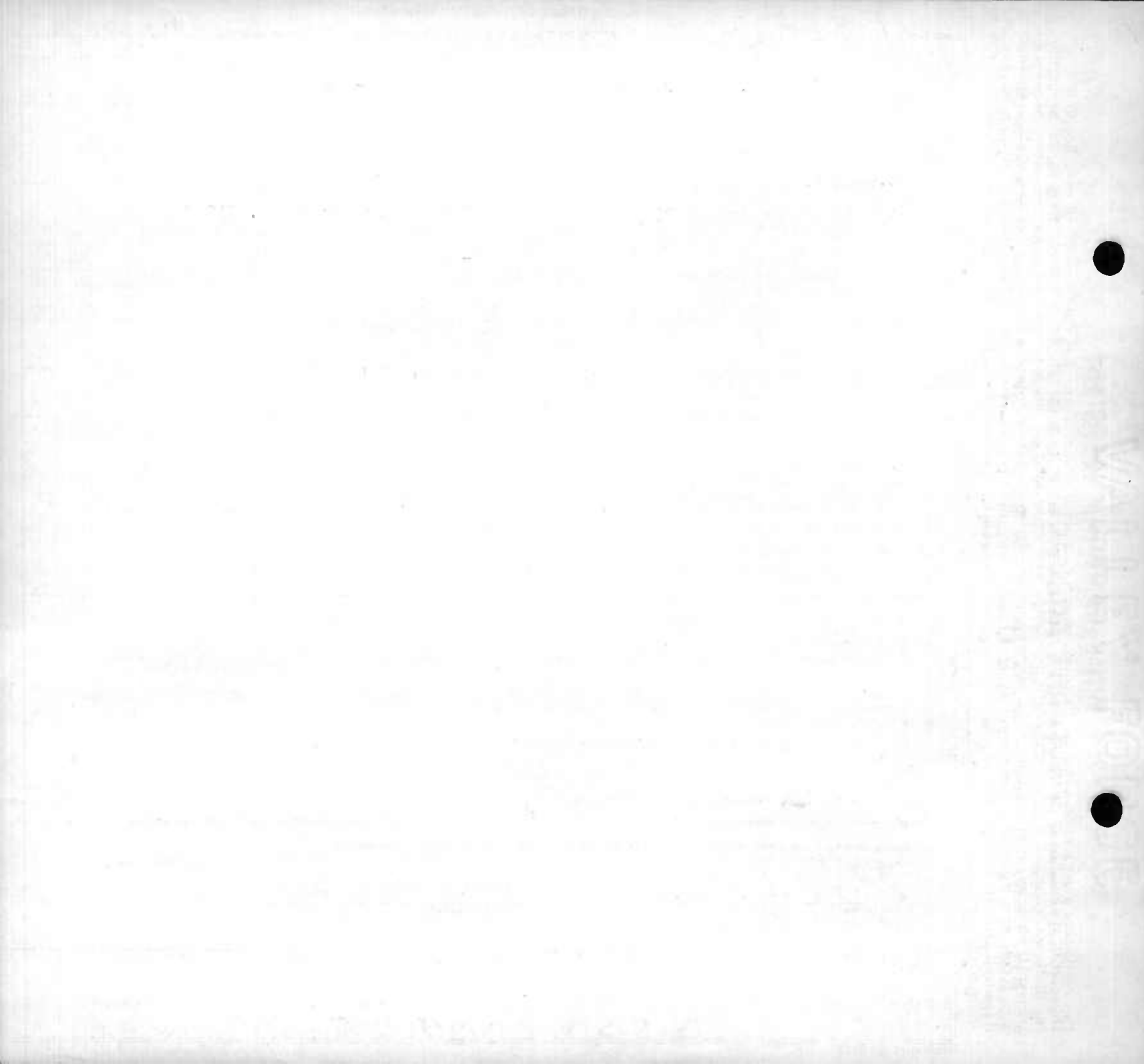
BIRTH NO. <b>65 2887</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2887</b>	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH <b>3-12-65 1:40 P.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>O'NEILL, WALTER LEE Sr.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVENUE BALTIMORE, MARYLAND</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>CATONSVILLE, 53-00</b>			
		D. STREET ADDRESS (If rural, give location) <b>6108 REGENT PARK</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED <b>MARRIED</b> (specify)	8. DATE OF BIRTH <b>1-23-92</b>	9. AGE (In years) <b>73 years</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM O'NEILL</b>			
14. MOTHER'S MAIDEN NAME <b>UNKNOWN Sarah</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>216-07-7818</b>		17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>			
18. <b>260 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Diabetes mellitus</b>		CAUSE OF DEATH (A) DUE TO <b>Myocardial Infarction</b> (B) DUE TO <b>Hypoprothrombinemia, with GI bleeding</b> (C)		INTERVAL BETWEEN ONSET AND DEATH <b>unknown 48-72 hrs 24-48 hrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 8 4</b> 19 <b>65</b> to <b>MARCH 12</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>MARCH 12</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Marstan A. Young</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>MARCH 12, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARSTAN A. YOUNG</b>		23D. ADDRESS <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/16/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Landon</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 17 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Staley H.D.</b>		25C. FUNERAL DIRECTOR <b>W. H. 4101 Edmondson</b>		ADDRESS <b>are</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

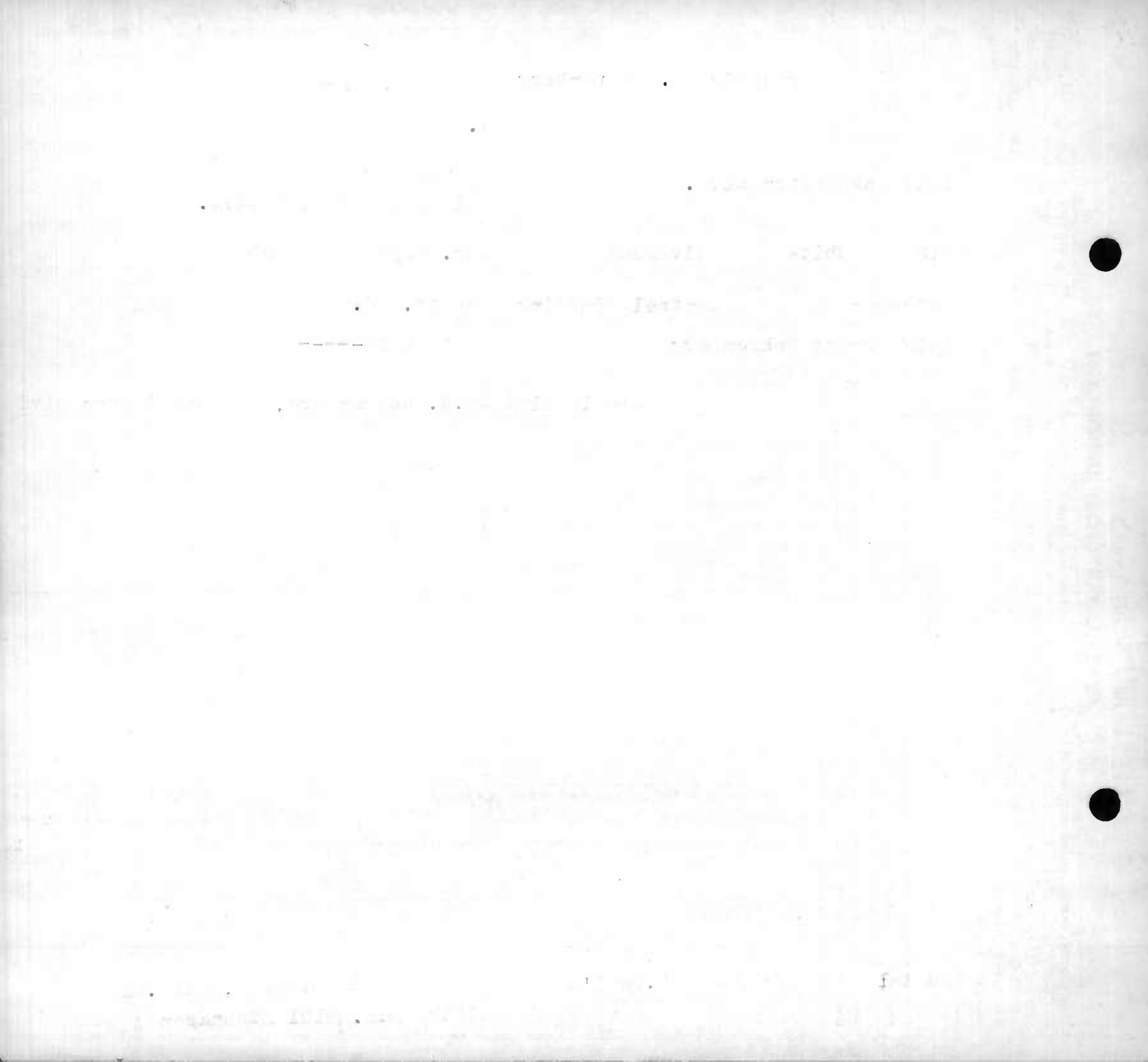
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 2888</span>	
BIRTH NO. <span style="font-size: 2em;">65 2888</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Shipferling, Arthur P. Jr.</u>		2. DATE AND HOUR OF DEATH <u>3-15-65</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Agnes Hospital</u> <u>Caton &amp; Wilkens Ave 21229</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>5203 Old Frederick Rd. 21229</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>5-30-91</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>B.I.C.R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Frederick I. Shipferling</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Clara Lee Shipferling (Same)</u>	
18. <u>4-20-1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u>		CAUSE OF DEATH (A) <u>Acute Myocardial Infarction</u> DUE TO <u>Angina (Hx of 3 Previous Infarctions)</u> (B) <u>Years</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>Hrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>MARCH</u> 19 <u>65</u> , that (we) last saw the deceased alive on <u>10 Mar</u> 19 <u>65</u> and that (we) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard Kelly</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/18/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 17 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Sabin</u>		25C. FUNERAL DIRECTOR <u>W. J. P. Funeral Directors</u>			
ADDRESS <u>4101 Edmond Ave</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2889</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2889</b>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		M.	
<b>Frederick C. Wehrenberg</b>		<b>3/14/65</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>1217 Washington Blvd.</b>		A. STATE <b>Md.</b> B. COUNTY <b>21-02</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>1217 Washington Blvd.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Jan. 19/85</b>	9. AGE (In years lost birthday) <b>80</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Central Parking</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>late Ernest Wehrenberg</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth-----</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>214 14 5122</b>		17. INFORMANT ADDRESS <b>Wm.H. Wehrenberg, 1217 Washington Blvd</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>260X I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <b>Nephrosclerosis, chronic</b> DUE TO		<b>5 months</b>	
		(B) <b>Diabetes Mellitus</b> DUE TO		<b>5 years</b>	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Ulcers chronic both legs</b>		<b>2 years</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/18/1957</b> to <b>3/14/1965</b> , that (I) (we) last saw the deceased alive on <b>3/14/1965</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John P. Urlock Jr.</b>		M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/16/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN P. URLOCK JR</b>		23D. ADDRESS <b>1227 Washington Blvd</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/17/65</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Paul's</b>	
24D. LOCATION (City, town, or county) (State) <b>Violetville, Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 17 1965</b>			
25B. NAME OF REGISTRAR <b>Witzke F.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>4101 Edmondson Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <span style="font-size: 1.5em;">65 2890</span>	
BIRTH NO. <span style="font-size: 1.5em;">65 2890</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">McDowell, Willie</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3/15/65</span> <span style="font-size: 1.2em;">6:30 P.</span> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">Montebello State Hospital</span>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">1901</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">312 N. Parrish St.</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">Negro</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Separated</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">2/4/1912</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">53</span>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Odd Jobs</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">South Carolina</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Willie McDowell</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Lillie Kennedy</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">Unknown</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Hospital Records</span>		
18. <span style="font-size: 1.5em;">150X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Carcinoma of Esophagus with Metastasis</span> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Carcinoma of Esophagus with Metastasis</span> (B) DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">one yr.</span>			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">no</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3/15/65</span> 19 to <span style="font-size: 1.2em;">3/15/65</span> 19, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3/15/65</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.5em;">Daniel G. Lai</span>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">3/15/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Daniel G. Lai</span>				23D. ADDRESS M.D. <span style="font-size: 1.2em;">2201 Argonne Drive, Baltimore, Md.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">3/18/65</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Sumpter</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">South Carolina</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">MAR 17 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Adolphus Halstead 918 Druid Hill Ave</span>			





65 2891

BALTIMORE CITY HEALTH DEPARTMENT

65 2891

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MAUDE McDORMAN LIBERTO DUVALL

2. DATE AND HOUR PRONOUNCED DEAD

March 13, 1965 9:20 A

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

884 W. Baltimore Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 3, 1911

9. AGE (In years  
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Dayton, Ohio

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

?

McDorman

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Ernest DuVall, Severna Park, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Acute Ethylism.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Heart Disease.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/13/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/17/65

23C. NAME of CEMETERY or CREMATORY

Glen Haven Memorial

23D. LOCATION

(City, town, or county)

(State)

Glen Burnie, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 17 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Kirkley Funeral Home, Glen Burnie

# WALLLEY FOREGE

4-1530 DNT

Class 1/2

often have reported

known to Thomas, and

BIRTH NO. 65 2892 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2892

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)B.  
CARL RUGE

2. DATE AND HOUR PRONOUNCED DEAD

March 15, 1965

3:33 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Michigan

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Muskegon

D. STREET ADDRESS (If rural, give location)

62½ Isabella Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

11/18/ 07

9. AGE (In years  
lost birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

OHIO

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

CARL A. RUGE

14. MOTHER'S MAIDEN NAME

MARIE THOMPSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

VIRGINIA RUGE, MUSKEGON, MICHIGAN

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular  
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-16-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

3/20/65

23C. NAME of CEMETERY or CREMATORY

OAKWOOD CEMETERY

23D. LOCATION

(City, town, or county)

MUSKEGON, MICHIGAN

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 17 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

HOWARD H. HUBBARD FUNERAL HOME

ADDRESS

4107 WILKENS AVE. 21229

100-1111

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

MEMORANDUM FOR THE ATTORNEY GENERAL

DATE: 10/1/68

TO: THE ATTORNEY GENERAL

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

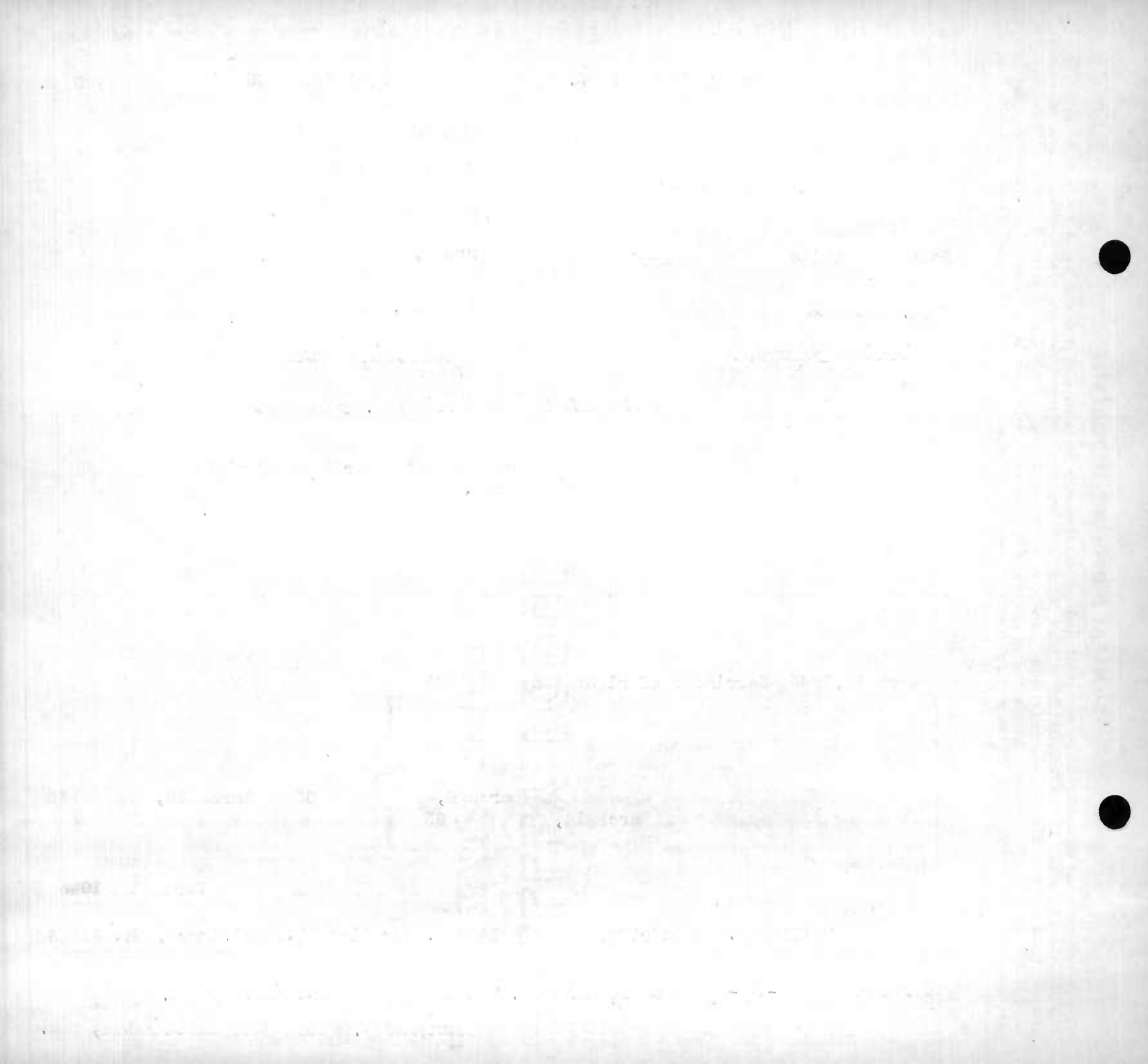
15. [illegible]

*[Handwritten signature]*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2893		CERTIFICATE OF DEATH		Registered No. 65 2893	
1. NAME OF DECEASED (Type or Print) <b>Fletcher, Raymond T.</b>				2. DATE AND HOUR OF DEATH <b>March 16, 1965</b>				9:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Joseph Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21204</b> D. STREET ADDRESS (If rural, give location) <b>8454 Loch Raven Blvd.</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>March 9, 1902</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Barber</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William Fletcher</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Worm</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>212321882</b>		17. INFORMANT <b>Lillian M. Fletcher</b>		ADDRESS <b>same</b>		
18. <b>163 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of lower lobe of right lung.</b>				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO					
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>March 15, 1965</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of right lung</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>March 6, 1965</b> to <b>March 16, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 16, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>William B. VandeGrift</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>March 16, 1965</b>			
23C. PHYSICIAN'S NAME (Type) <b>William B. VandeGrift,</b>				23D. ADDRESS <b>1400 N. Caroline St., Baltimore, Md. 21213</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>3-19-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Morland Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 17 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc</b>		ADDRESS <b>Baltimore, Md.</b>			

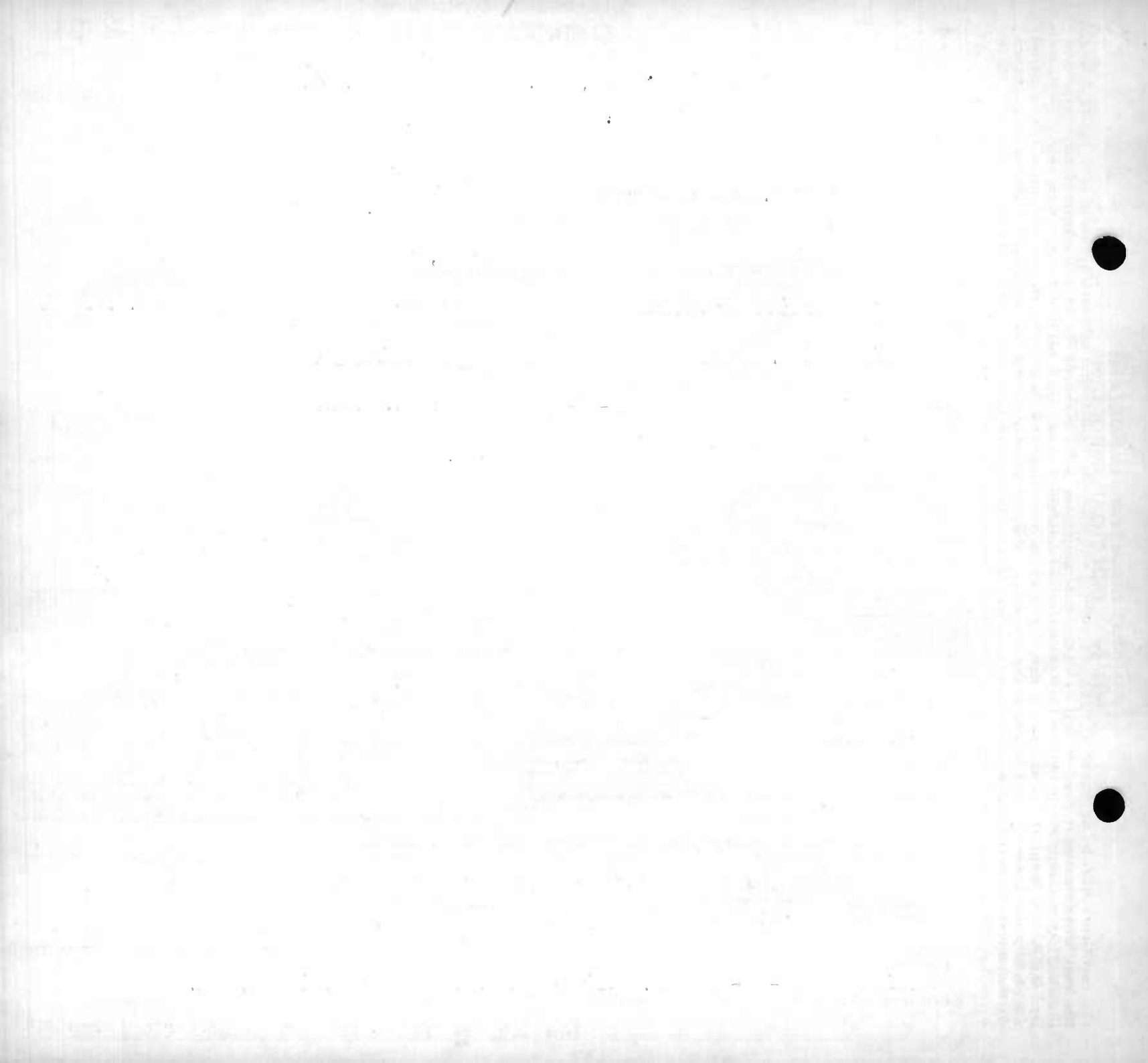




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

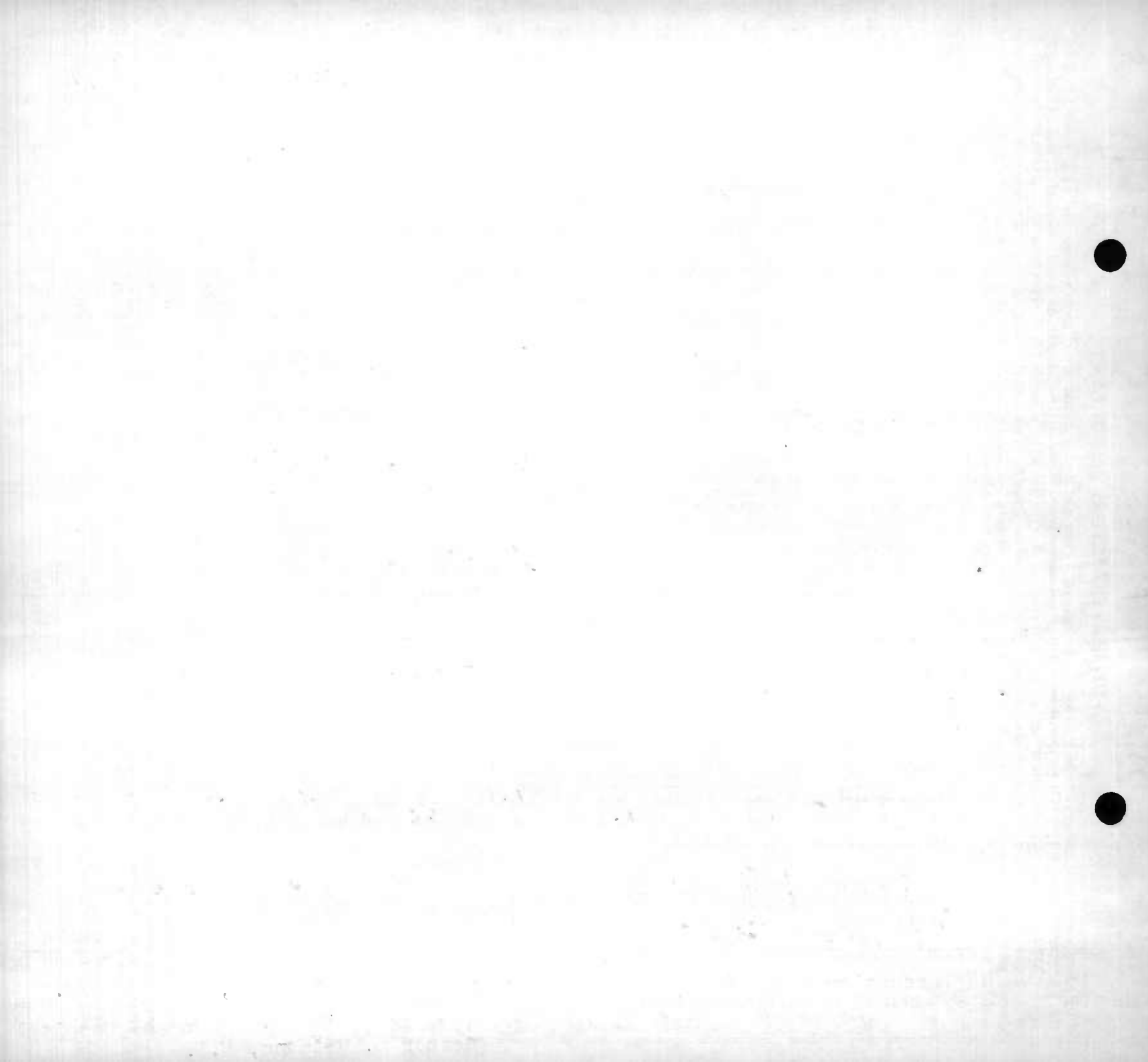
BIRTH NO. 65 2894				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2894	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Jerome Leo Hahn, Sr.</b>				2. DATE AND HOUR OF DEATH <b>Mar. 16, 1965 12 45 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>5011 E. Federal Street</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-34</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>5011 E. Federal Street</b>			
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widower</b>	8. DATE OF BIRTH <b>Oct 17, 1890</b>	9. AGE (in years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machine Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael J. Hahn</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Ford</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-03-1284</b>		17. INFORMANT <b>Paul L. Hahn</b>		ADDRESS <b>same</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of stomach</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Rheumatic valvular disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>							
19A. DATE OF OPERATION <b>0 none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>19 55</b> to <b>3-15</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3-15</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>J. Duer Moores</b> M.D.				23B. DATE SIGNED <b>3-17-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>J. DUEVER MOORES</b> M.D.				23D. ADDRESS <b>3105 BELAIR RD 21213</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>3-20-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 17 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Staph...</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc</b> ADDRESS <b>5305 Harford Road #14</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2895		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 28954	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby Girl HALL		2. DATE AND HOUR OF DEATH 3-3-65 1:35 PM. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HOSPITAL for Women of Md.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1509 W. MT Royal Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3-3-65	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John William Hall		14. MOTHER'S MAIDEN NAME Virginia Gertrude Hall	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Admission Sheet	
18. 762.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Severe cerebral anoxia</u> (B) <u>Asphyxia</u> (C) <u>Asphyxia</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAR 3 19 65 to MAR 3 19 65, that (I) (we) last saw the deceased alive on MAR 3 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Estelita F. Gensoli		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-3-65	
23C. PHYSICIAN'S NAME (Type) ESTELITA F. GENSOLO		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 3/5/65		24C. NAME OF CEMETERY or CREMATORY Womens Hospital	
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Dexter L. Reimann, M.D.	
25D. ADDRESS Womens Hospital					



1  
L-522

65 2896

BALTIMORE CITY HEALTH DEPARTMENT

65 2896

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HERBERT A. LANCASTER

2. DATE AND HOUR PRONOUNCED DEAD

March 14, 1965 11:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2008 Deering Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 15, 1910

9. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mail Clerk

10B. KIND OF BUSINESS OR INDUSTRY

B.O.R.R.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William H. Lancaster

14. MOTHER'S MAIDEN NAME

Catherine Hoffman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.

216-03-5294

17. INFORMANT

ADDRESS

Martha M. Lancaster-2008 Deering Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Peter W. Rieckert, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

3-15-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3-18-65

23C. NAME of CEMETERY or CREMATORY

Meadowridge Mem. Park

23D. LOCATION

(City, town, or county)

Howard Co. Dorsey, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 17 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

F. R. Wipert - 1300 E. FULTON

ADDRESS

WALLEN BOYD

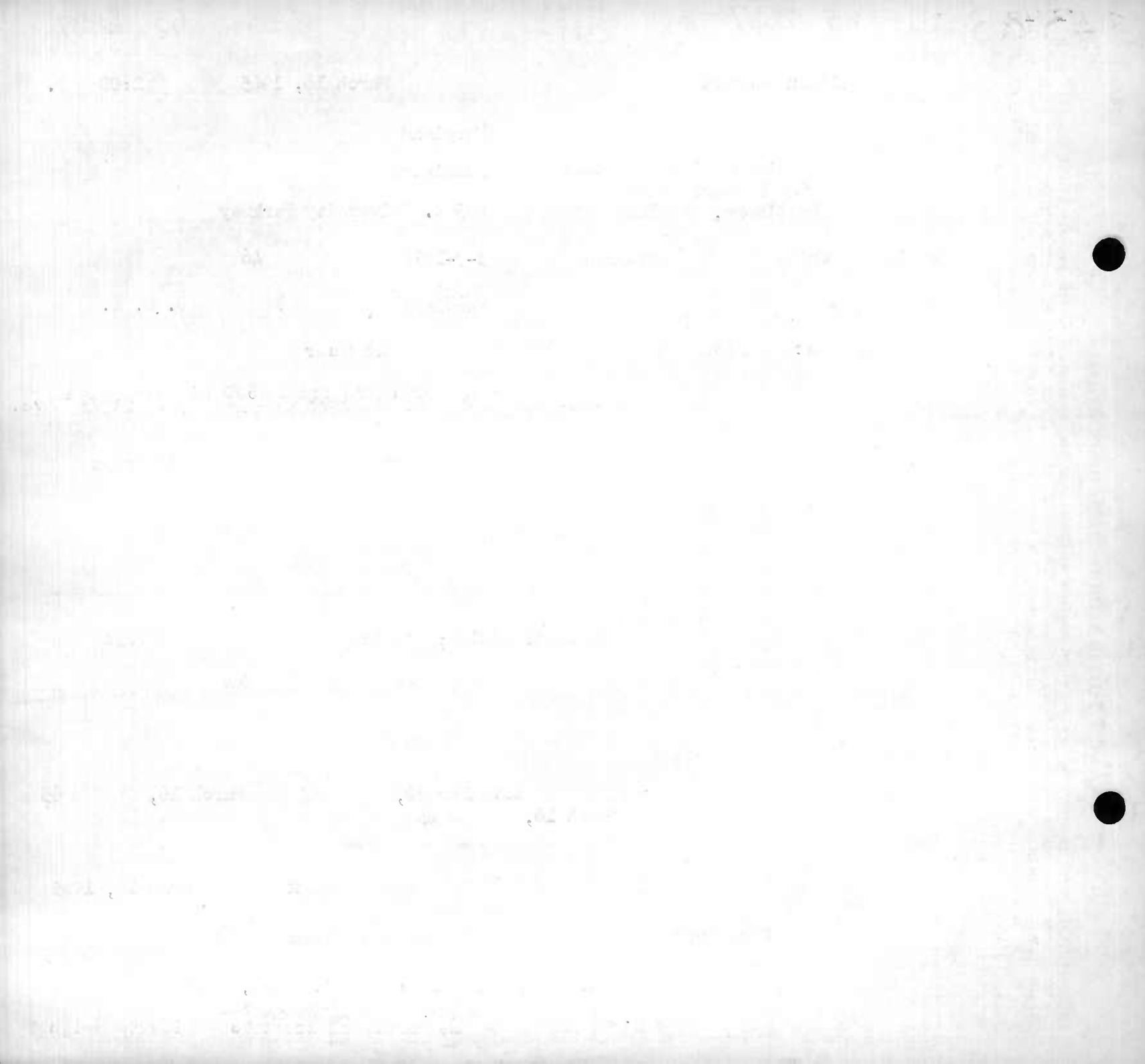
JACOBSON

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 2897</u>	
BIRTH NO. <u>65 2897</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Aileen Stewart</b>		2. DATE AND HOUR OF DEATH <b>March 16, 1965</b>   <b>2:00 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>27-14</b> D. STREET ADDRESS (If rural, give location) <b>853 W. University Parkway</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>	8. DATE OF BIRTH <b>5-9-1918</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>46</b>
13. FATHER'S NAME <b>Lawrence Mallon</b>		14. MOTHER'S MAIDEN NAME <b>Edna Mae Auer</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-18-9019</b>	
17. INFORMANT <b>Ellsworth Armacost 4600 Liberty Heights</b>		ADDRESS <b>RECORDS &amp; EXH 4940 Eastern Avenue 21224 Ave.</b>	
18. <b>704.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pemphigus (Bullous)</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Pemphigus (Bullous)</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>10 Years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Hypersteroidism; Sepsis</b>		3 Days	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 30,</b> 19 <b>64</b> to <b>March 16,</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>March 16,</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>ey Cooke</i> <b>Robert Cooke</b>		23B. DATE SIGNED <b>March 16, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert Cooke</b>		23D. ADDRESS <b>4940 Eastern Avenue 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/20/65</b>	
24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 18 1965</b>		25B. NAME OF REGISTRAR <i>Robert E. Fagan M.D.</i>	
25C. FUNERAL DIRECTOR <b>Ellsworth Armacost</b>		ADDRESS <b>Ellsworth Armacost 4600 Liberty Heights</b>	

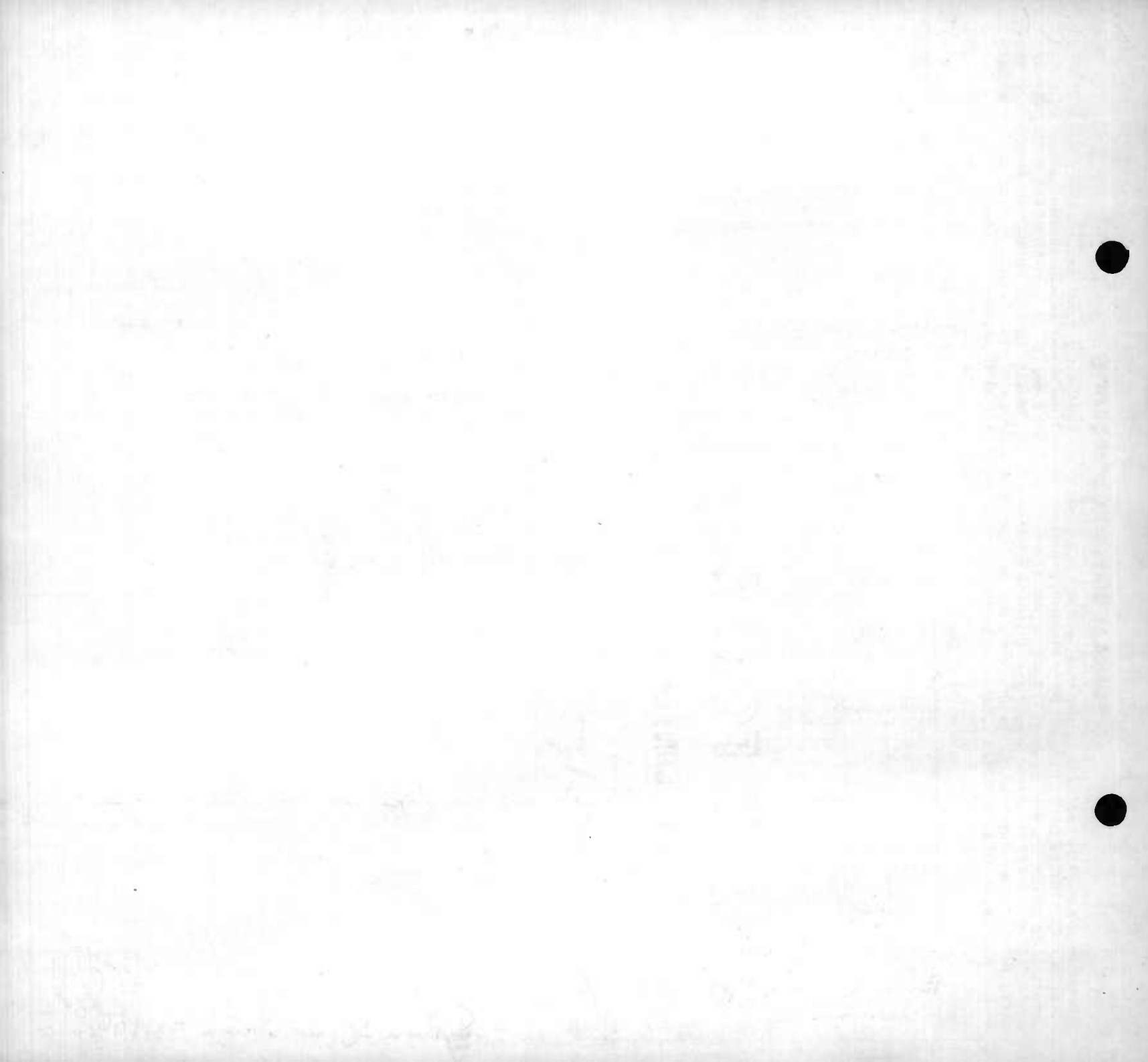




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2898		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 30-70-43	
M.E. CASE NO.		CERTIFICATE OF DEATH		65 2898	
1. NAME OF DECEASED (Type or Print) Alex Estrin		2. DATE AND HOUR OF DEATH 3/16/65 1:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Laurel C. CITY OR TOWN (If outside city limits, write RURAL and give township) Laurel D. STREET ADDRESS (If rural, give location) Turf Motor Court			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH ?	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reporter		10B. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) ENGLAND	
13. FATHER'S NAME ? MAX		14. MOTHER'S MAIDEN NAME LEAH		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Deline Baker Daughten	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE		CAUSE OF DEATH (A) Acute Myocardial Infarction DUE TO (B) Obesity + Hypertension DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4 3/4 hrs	
19A. DATE OF OPERATION 2 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 11:30 PM 3/15/65 to 1:45 AM 3/16 1965, that (1) (we) last saw the deceased alive on 3/16/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry H. Bohlman, M.D.		23B. DATE SIGNED 3/16/65			
23C. PHYSICIAN'S NAME (Type) Henry H. Bohlman		23D. ADDRESS University Hospital Md.			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/65		24C. NAME OF CEMETERY or CREMATORY West Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Norridge Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 18 1965		25B. NAME OF REGISTRAR Robert E. Fink, M.D.	
25C. FUNERAL DIRECTOR ADDRESS		25D. FUNERAL DIRECTOR		25E. FUNERAL DIRECTOR ADDRESS 3319 Olympia	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2899

BIRTH NO. 65 2899

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LEONTINE PUKK

2. DATE AND HOUR PRONOUNCED DEAD

March 16, 1965

11:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4510 Pen Lucy Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 11, 1899

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Wife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Leningrad

12. CITIZEN OF  
WHAT COUNTRY?

Res. Alien USA

13. FATHER'S NAME

August Eichhorn

14. MOTHER'S MAIDEN NAME

Henriette Kilgas

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. If yes, give war or dates of service)

NO

NO

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

ADDRESS

Eugene Pukk 1543 Langford Rd. #7

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) DUE TO Massive pulmonary embolism  
popliteal vein phlebothrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-16-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/19/65

23C. NAME OF CEMETERY or CREMATORY

Lorraine

23D. LOCATION

(City, town, or county)

Baltimore &amp; 7 Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 18 1965

24B. NAME OF REGISTRAR

Robert E. Fairley, M.D.

24C. FUNERAL DIRECTOR

John T. Stansbury 6411 Windsor Mill

ADDRESS

1952. 11. 15

1952. 11. 15

1952. 11. 15

1952. 11. 15

1952. 11. 15

1952. 11. 15

1952. 11. 15

1952. 11. 15

*John D. ...*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 2900		<b>CERTIFICATE OF DEATH</b>		65 2900	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Annie L. Young</i>		2. DATE AND HOUR OF DEATH <i>3/16/1965</i> <i>9 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>21-02</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>1235 James St.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>1235 James St.</i>			
5. SEX <i>Female</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>2/11/1879</i>	9. AGE (In years lost birthday) <i>86</i>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Work</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Pentz</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>✓</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mr. Alfred Young</i> ADDRESS <i>813 Evesham Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>600.01 + 260X</i>		CAUSE OF DEATH (A) DUE TO <i>Uremia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>II Diabetes mellitus</i>		(B) DUE TO <i>Chronic pyelonephritis</i>		<i>2</i>	
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>March 14</i> 19 <i>65</i> to <i>March 16</i> 19 <i>65</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>March 16</i> 19 <i>65</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) ( <del>not</del> ) view the body after death.					
23A. SIGNATURE <i>Ricardo Lozada</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3/17/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>RICARDO LOZADA</i>		23D. ADDRESS <i>1228 S. Charles St. Balto 30, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/19/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven Cem. Glen Burnie, Md.</i>	
24D. LOCATION (City, town, or county) (State) <i>23. md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 18 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Joseph J. Brownston Inc.</i>		ADDRESS <i>901 St.</i>			

1894

1895

1896

1897



## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 2901 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2901

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EARL

HARTSELL

2. DATE AND HOUR PRONOUNCED DEAD

March 14, 1965

10:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Pasadena

D. STREET ADDRESS (If rural, give location)

Route 9, Box 410

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 31, 1924

9. AGE (In years  
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Welder

10B. KIND OF BUSINESS OR INDUSTRY

Md. Dry Dock

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lonnie L. Hartsell

14. MOTHER'S MAIDEN NAME

Gertie Cress

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 11

16. SOCIAL  
SECURITY NO.  
27-16-8028  
Unknown

17. INFORMANT

ADDRESS

Mrs. Helen F. Hartzell (wife) Same As #4

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty liver  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Chronic alcoholism  
DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type) Peter W. Rieckert, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

3-15-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

March 18/65

23C. NAME of CEMETERY or CREMATORY

Glen Haven Memorial Pk. Glen Burnie, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 18 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

R.V. Singleton, Glen Burnie, Md.

ADDRESS

WALTER H. HARRIS

PAID BY THE

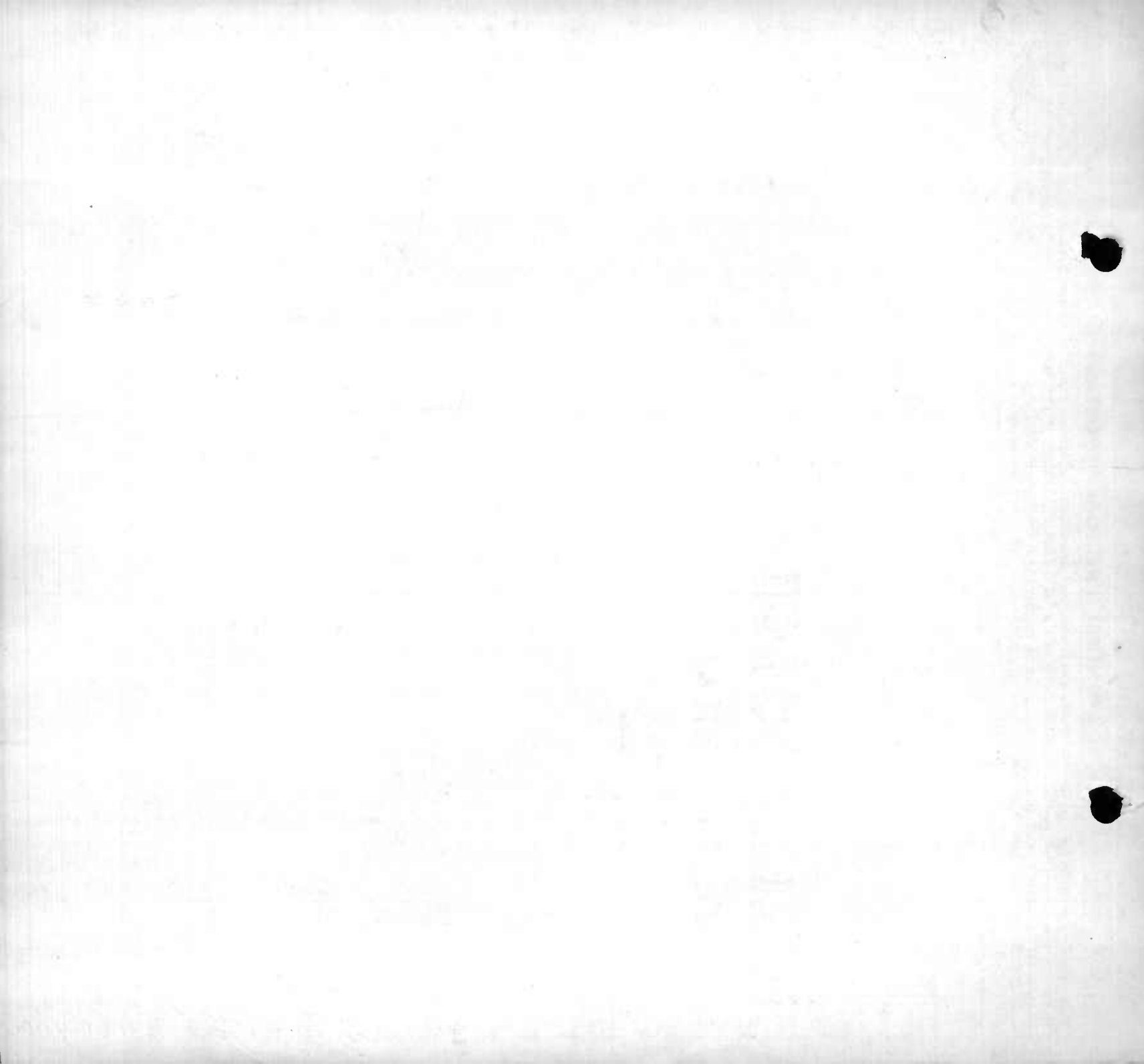
W. H. HARRIS

W. H. HARRIS, 1000 1st St. N. W., Wash. D. C.  
W. H. HARRIS, 1000 1st St. N. W., Wash. D. C.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

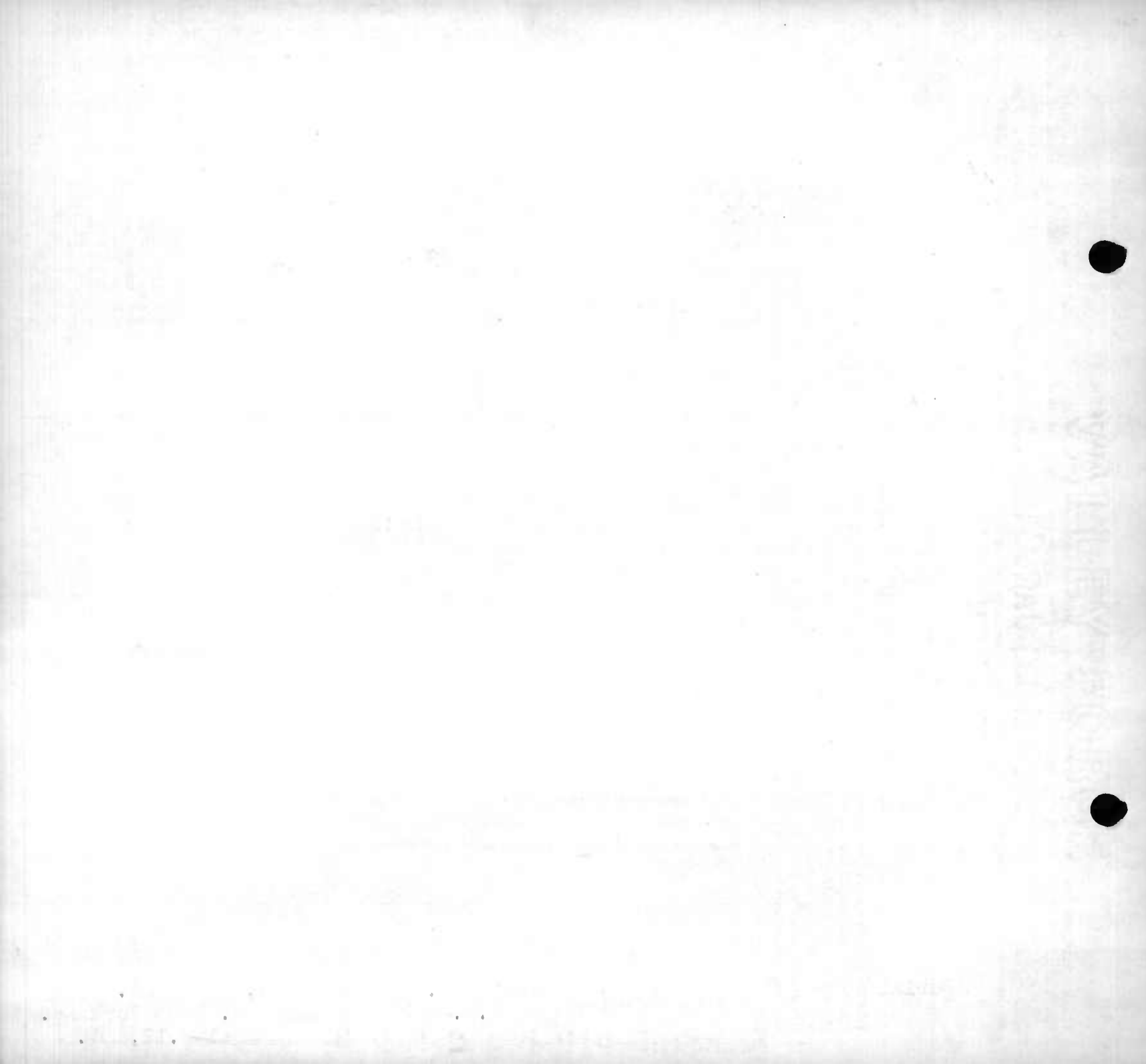
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2902	
BIRTH NO. 65 2902		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ANBINDER, ISIDORE</b>		2. DATE AND HOUR OF DEATH <b>3/16/65 - 7:30 PM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Sinai Hospital</b>		A. STATE <b>MD.</b> B. COUNTY <b>27-17</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BAL.</b>			
		D. STREET ADDRESS (If rural, give location) <b>5011 Queensberry Ave. #15</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWER</b>	8. DATE OF BIRTH <b>10/15/1897</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>usa</b>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hosp Chart</b> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) DUE TO <b>MIOCARDIAL Infarction</b>		<b>36.</b>	
		(B) DUE TO <b>Coronary insufficiency</b>			
		(C) <b>Recurrent Ca. of sigmoid</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Recurrent Ca. of sigmoid</b>			
19A. DATE OF OPERATION <b>1/31/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca. bleeding</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED (Whilo At Work <input type="checkbox"/> Not Whilo At Work <input type="checkbox"/> )		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/14/65</b> 19 to <b>3/16/65</b> 19, that (I) (we) last saw the deceased alive on <b>3/16/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jorge Odoñez</b>		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/16/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jorge Odoñez</b>		23D. ADDRESS <b>M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/17/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Southern Ave</b>	
24D. LOCATION (City, town, or county) <b>Balto</b>		24E. (State) <b>md</b>		24F. (Zip) <b>21204</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 18 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son</b> ADDRESS <b>3319 Olympia Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2903		CERTIFICATE OF DEATH		Registered No. 65 2903	
1. NAME OF DECEASED (Type or Print) <b>RENNIE, MALCOLM E.</b>				2. DATE AND HOUR OF DEATH <b>March 14, 1965 10.15 P. M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL 827 LINDEN AVE BALTO 1, MD.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-48</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 12</b> D. STREET ADDRESS (If rural, give location) <b>804 E. LAKE AVE.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>11-13-02</b>		9. AGE (in years last birthday) <b>62</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Supt. Eng. Dept U.S.F. &amp; G.</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT H. RENNIE</b>				14. MOTHER'S MAIDEN NAME <b>DELIA JOYCE</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-07-8531</b>		17. INFORMANT ADDRESS <b>Admission sheet of M.C. H</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>332X1</b>				CAUSE OF DEATH (A) <b>CEREBRAL THROMBOSIS</b> DUE TO <b>with RT emiplegia</b> (B) <b>Prob. HYPERTENSION</b> DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH <b>about 3 mos</b>	
19. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/14/65</b> 19 <b>65</b> to <b>3/14</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3/14</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Pietro Lastucci</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/14/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>PIETRO LASTUCCI</b>				23D. ADDRESS M.D. <b>5907 CHINQUAPIN PKWY, BALTO 12</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/17/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 18 1965</b>				25B. NAME OF REGISTRAR <b>Philip E. Talley</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>			

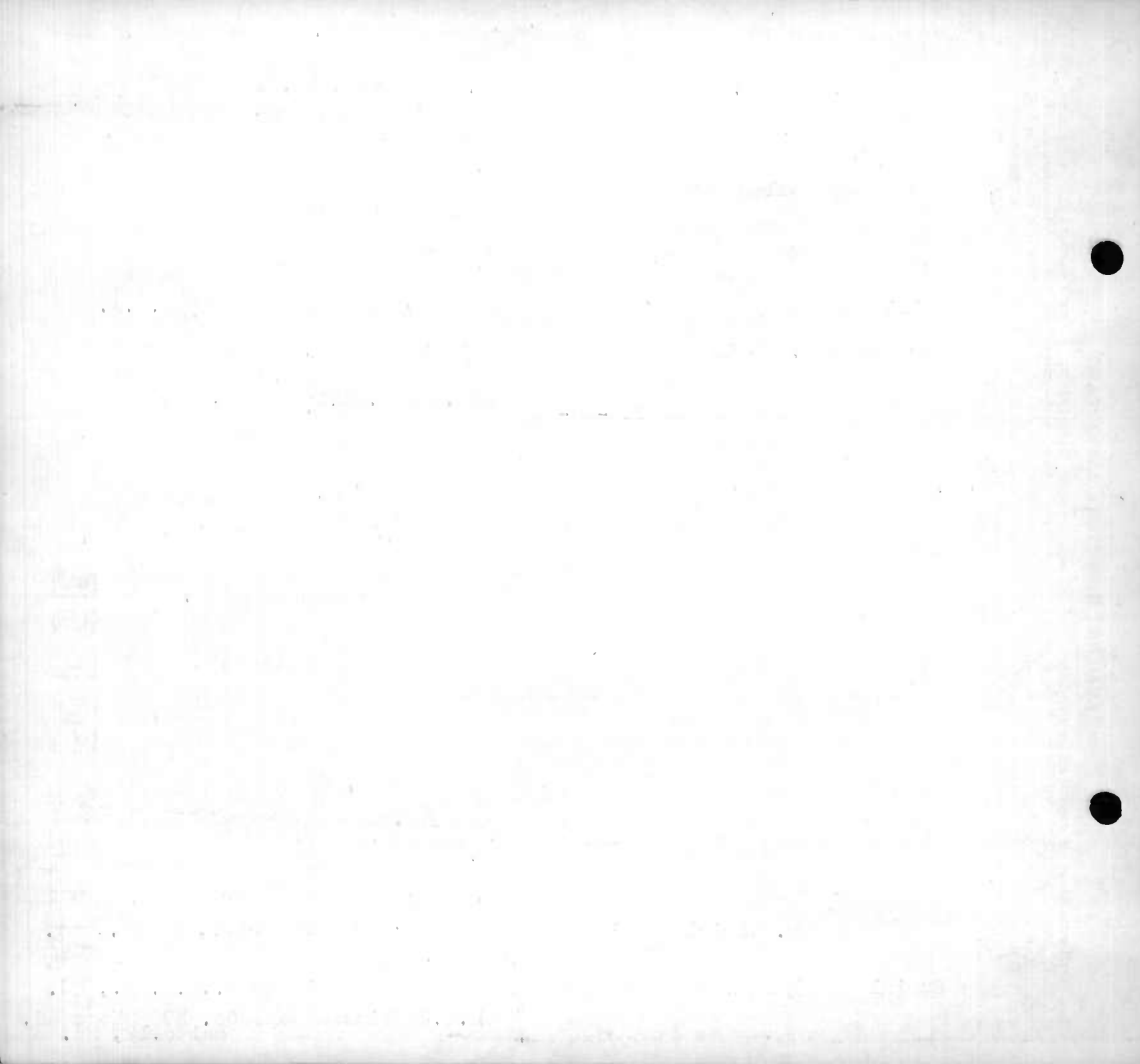


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2904				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2904	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>George W. Kloid</b>				2. DATE AND HOUR OF DEATH <b>March 16, 1965</b>   <b>12:30 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>503 Hollen Road</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-48</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>503 Hollen Road</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>3/18/1908</b>	9. AGE (In years lost birthday) <b>56</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Finisher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick W. Kloid</b>				14. MOTHER'S MAIDEN NAME <b>Mary Regina LaBarre</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-09-8296</b>		17. INFORMANT <b>Mrs. Eva E. Kloid</b>		ADDRESS <b>(Same)</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Carcinoma, lung.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Metastatic Carcinoma, lung.</b> DUE TO (B) <b>9 mos</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>6/6/64 - Biopsy</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Biopsy, Cerv. node</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 9 1964</b> to <b>16 March 1965</b> , that (I) (we) last saw the deceased alive on <b>March 11 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.							
23A. SIGNATURE <b>Daniel Bakal, MD</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>17 March 65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Daniel Bakal</b>				23D. ADDRESS <b>3600 Lochearn Drive, Balto., Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/19/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Ritchie Hwy., A.A.Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 18 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Staley, MD</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd. Balto., Md.</b>	





BIRTH NO.

65 2905

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

FRANK P. MONTEFERRANTE

2. DATE AND HOUR PRONOUNCED DEAD

March 15, 1965

8:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2109 Dobler Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2109 Dobler Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

AUG 24 1882

9. AGE (In years  
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

ITALY

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

GIOVANNI MONTEFERRANTE

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

PAUL MONTEFERRANTE

ADDRESS

2109 DOBLER AVE.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Asphyxia due to hanging  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

2109 Dobler Avenue

21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

Found: 3-15-65 6:30A.m.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Hanged self with rope

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type) Peter W. Rieckert, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

3-15-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

MARCH 18

23C. NAME OF CEMETERY or CREMATORY

HOLY REDEEMER

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE - MD

24A. DATE REC'D BY HEALTH DEPT.

MAR 18 1965

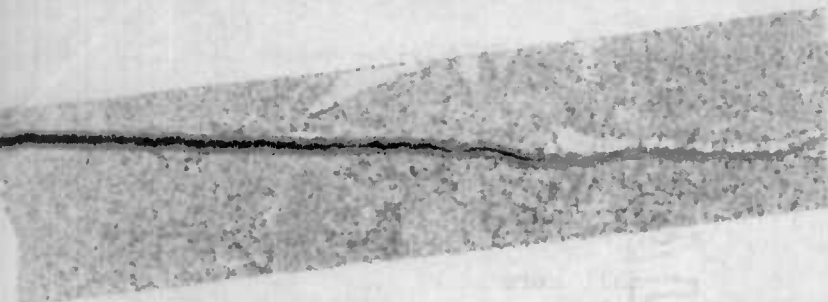
24B. NAME OF REGISTRAR

Robert E. Zappala

24C. FUNERAL DIRECTOR

F.W. BZAREWSKI - 1930 EASTERN AVE.

ADDRESS 21231



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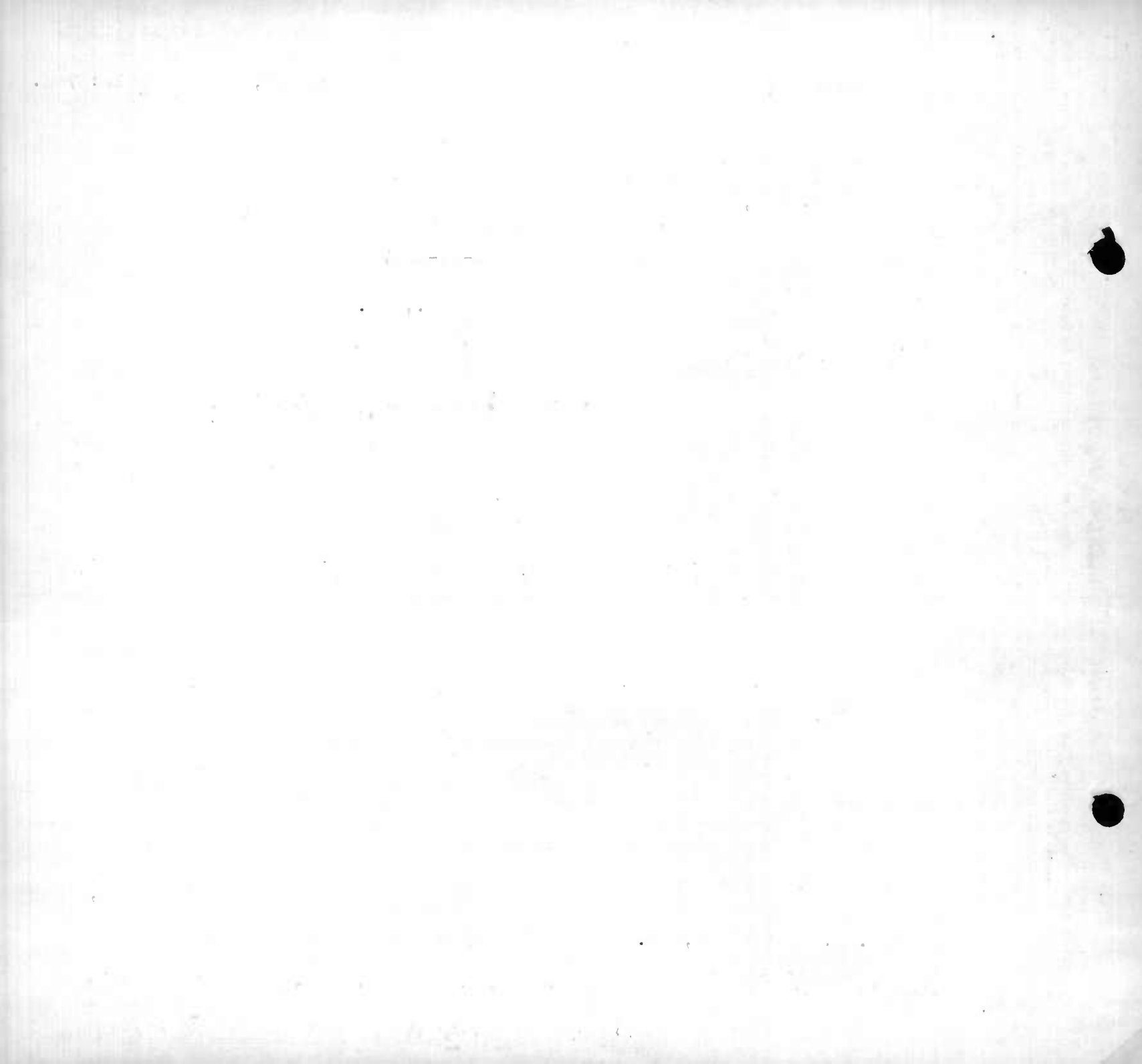
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1-11-11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2906</u>	
BIRTH NO. <u>65 2906</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Emeline Johnson</u>		2. DATE AND HOUR OF DEATH <u>March 16, 1965</u>   <u>11:37 a.m.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u>		A. STATE <u>Maryland</u> B. COUNTY <u>14-02</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1609 Division Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>1-14-1897</u>	9. AGE (In years lost birthday) <u>68</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>HARRY Johnson</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE GRANT</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-89-7411</u>		17. INFORMANT ADDRESS <u>Elma Tripp 1609 Division St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>DUODENAL FISTULA</u>		CAUSE OF DEATH (A) <u>DUODENAL FISTULA</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HYDRO NEPHROSIS</u>		(B) <u>HYDRO NEPHROSIS</u> DUE TO		<u>10 YRS (?)</u>	
		(C) <u>RIGHT NEPHROLITHIASIS</u>		<u>10-15 YRS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>13/3/65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RENAL CALCULI &amp; HYDRO-NEPHROSIS</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>FEB. 26, 1965</u> to <u>MARCH 16, 1965</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>MARCH 16, 1965</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <u>R. A. Montgomery, Jr.</u> M.D.				23B. DATE SIGNED <u>March 16, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. A. Montgomery, Jr.</u>		23D. ADDRESS <u>2320 Eutaw Place</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-28-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>	
24D. LOCATION <u>Balto.</u>		(City, town, or county)		(State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 18 1965</u>		25B. NAME OF REGISTRAR <u>R. B. E. Jackson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Morgan &amp; Dyett 916 Penn Ave.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2907	
BIRTH NO. 65 2907		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 3/15/65 9:25 P.M.	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) CHARLES O'CONNELL					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE		A. STATE MARYLAND B. COUNTY BALTIMORE CITY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2808 EMERALD ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3/1/1911	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES		10B. KIND OF BUSINESS OR INDUSTRY GARY ELECT CO		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME CHARLES O'CONNELL			
14. MOTHER'S MAIDEN NAME URSULA M. SCHEEL		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII			
16. SOCIAL SECURITY NO. 212-05-2854		17. INFORMANT ADDRESS Virginia O'Connell 2808 Emerald Road BALTIMORE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) Cerebral Metastasis DUE TO		3 weeks	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Malignant Melanoma DUE TO		3 months	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/1/65 19 to 3/15/65 19, that (I) (we) last saw the deceased alive on 3/15/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Melvin J. Kordon		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/15/65	
23C. PHYSICIAN'S NAME (Type) M. J. Kordon		23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-14-65		24C. NAME of CEMETERY or CREMATORY MORELAND MEM. PARK	
24D. LOCATION (City, town, or county) BALTO		(State) MD			
25A. DATE REC'D BY HEALTH DEPT. MAR 18 1965		25B. NAME OF REGISTRAR Robert E. Starbuck		25C. FUNERAL DIRECTOR G. F. EDWARDS & SON 8802 Hartford Rd.	

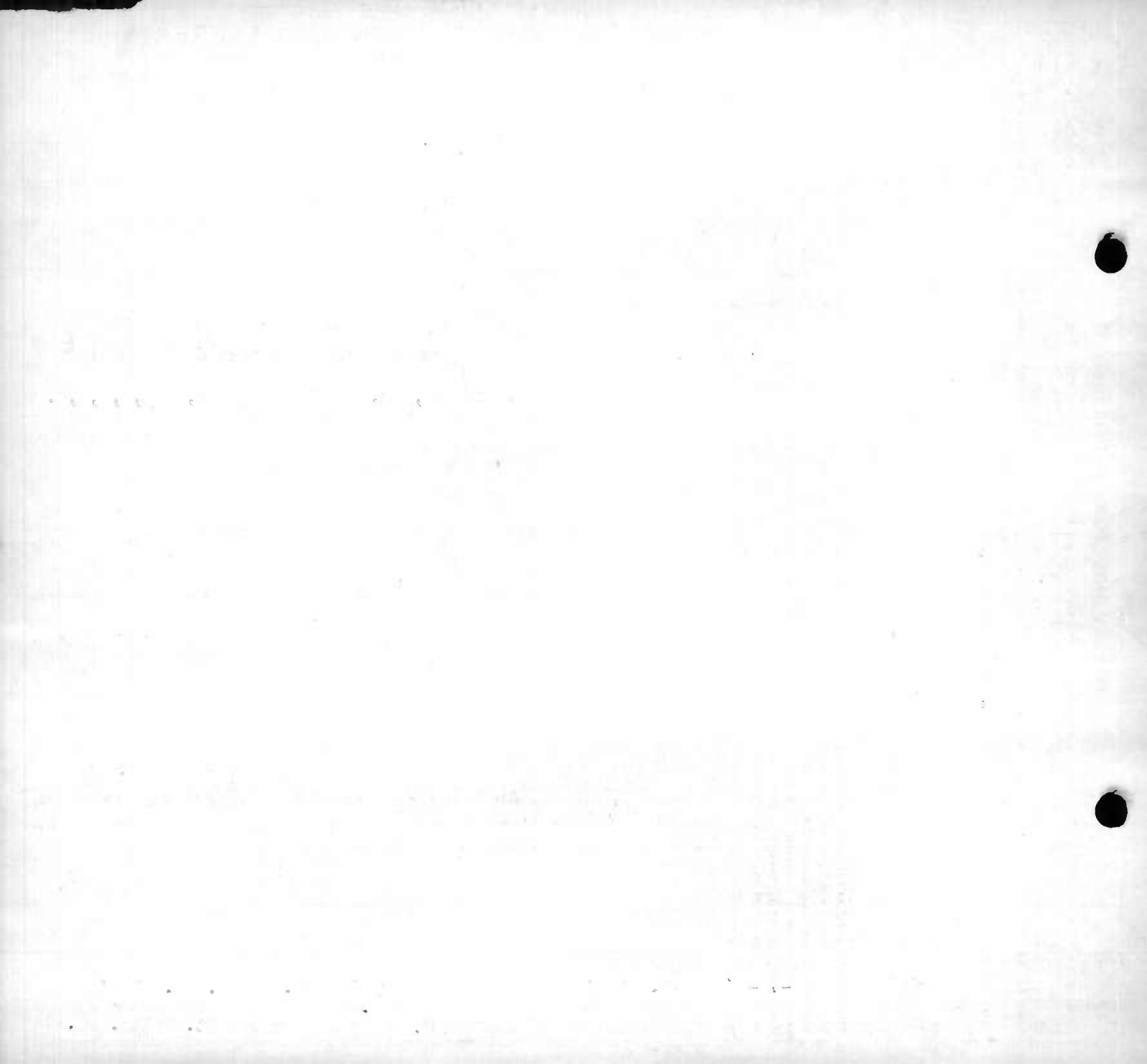




# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2908		CERTIFICATE OF DEATH		Registered No. 65 2908	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mildred Fowler			2. DATE AND HOUR OF DEATH March 15, 1965 4:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital			A. STATE Maryland B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 714 S. Ellwood St.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH February 28, 1907	9. AGE (In years lost birthday) 58	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Andrew Nawrocki		
14. MOTHER'S MAIDEN NAME JOANNA GALCZYNSKI			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No No		
16. SOCIAL SECURITY NO. 217-12-3158			17. INFORMANT Husband, Mr. Winfield Fowler, # 4, a, b, c, d.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH Metastatic Carcinoma of Stomach		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 14 1965 to March 15 1965, that (I) (we) last saw the deceased alive on March 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. G. Tilley				23B. DATE SIGNED Mar 15, 1965	
23C. PHYSICIAN'S NAME (Type) L. G. Tilley				23D. ADDRESS M.D. Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Mar-19-1965		24C. NAME of CEMETERY or CREMATORY St. Stanislaus	
24D. LOCATION Dundalk Ave. Balto. Md. 21224		25A. DATE REC'D BY HEALTH DEPT. MAR 18 1965		25B. NAME OF REGISTRAR Robert E. Foley	
25C. FUNERAL DIRECTOR ADDRESS JOHN G. DUDA 2829 Hudson St. Balto. Md. 24					



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 2909

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

65 2909  
George Redel

2. DATE AND HOUR OF DEATH

3/15/1965 5:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

90 HARTFORD GARDEN Nursing Home

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)  
A. STATE B. COUNTY

MD. BALTO 5300

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

PARKVILLE

D. STREET ADDRESS (If rural, give location)

9000 HARTFORD Rd

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

6/24/1884

9. AGE (In years last birthday)

80

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CARPENTER

10B. KIND OF BUSINESS OR INDUSTRY

Building

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Andrew Redel

14. MOTHER'S MAIDEN NAME

Margaret Rabb

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

216-039239

17. INFORMANT

Wife

ADDRESS

Same

18. 332X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Viral Pneumonitis

(A) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

18 hr.

(B) DUE TO

Cachexia & debilitation 1 month

(C) DUE TO

Cerebro-Vascular occlusion, cerebral ischemia 10 mos.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Myocardial degeneration

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 1962 to March 1965, that (I) (we) last saw the deceased alive on March 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Frank T. Kasik Jr.

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

3/16/65

23C. PHYSICIAN'S NAME (Type)

FRANK T KASIK JR

M.D.

23D. ADDRESS

9005 HARTFORD Rd

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

3/18/65

24C. NAME OF CEMETERY or CREMATORY

PARKWOOD

24D. LOCATION

BALTIMORE

(City, town, or county)

(State)

MD

25A. DATE RECD BY HEALTH DEPT.

MAR 18 1965

25B. NAME OF REGISTRAR

John E. Jenkins

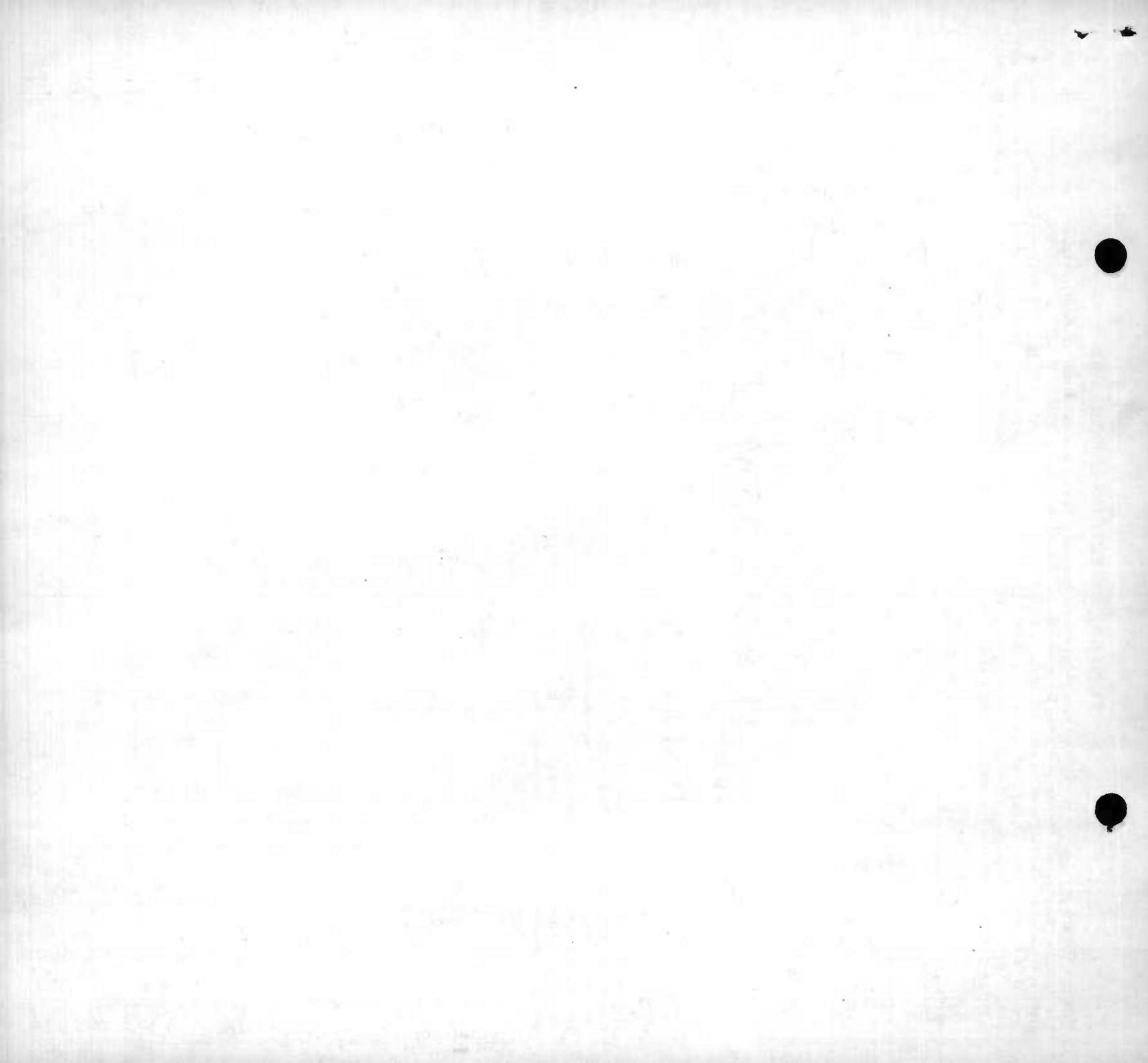
25C. FUNERAL DIRECTOR

CHAR F. EVANS

Ysm

ADDRESS

8802 HARTFORD Rd



BIRTH NO.

65 2910

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 2910

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES FRISBY

2. DATE AND HOUR PRONOUNCED DEAD

March 15, 1965

5:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

105 Barberrry Court

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Dec. 15, 1929

9. AGE (in years  
lost birthday)

35

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

George Frisby

14. MOTHER'S MAIDEN NAME

Elsie Burharna

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Korean

16. SOCIAL  
SECURITY NO.

168-24-3591

17. INFORMANT

Louise Frisby

ADDRESS

Mercersburg, Penna.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Embolic occlusion of right internal  
DUE TO carotid artery

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Mural thrombus in heart  
DUE TO acute myocardial infarction

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-16-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/18/65

23C. NAME OF CEMETERY or CREMATORY

Zion Union

23D. LOCATION

(City, town, or county)

Mercersburg, Penna.

24A. DATE REC'D BY HEALTH DEPT.

MAR 18 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Lininger Funeral Home Mercersburg, Pa.

VALLEY FORCE

John E. Hagan

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department										
BIRTH NO. 65 2911					CERTIFICATE OF DEATH			Registered No. 65 2911		
1. NAME OF DECEASED (Type or Print) <i>John Jackson</i>					2. DATE AND HOUR OF DEATH <i>Mar. 17, 1965 4:30 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>1613 McHenry Street</i>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1904</i>					
5. SEX <i>Male</i> 6. RACE <i>Colored</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>					8. DATE OF BIRTH <i>10-14-99</i> 9. AGE (In years last birthday) <i>65</i>					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Meat Cutter</i>					10B. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>James Jackson</i>					14. MOTHER'S MAIDEN NAME <i>Elizabeth Warner</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					
17. INFORMANT <i>Henrietta E. Jackson</i>					ADDRESS <i>1613 McHenry St</i>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Hemorrhage</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 Week</i>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arteriosclerotic Cardiovascular disease</i>					<i>13 years</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>July 11 1952</i> to <i>March 17 1965</i> , that (I) (we) last saw the deceased alive on <i>March 10 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE <i>William H. Watts</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>3-17-65</i>		
23C. PHYSICIAN'S NAME (Type) <i>William H. Watts</i>					23D. ADDRESS <i>515 N. Arlington Ave. Baltimore, Md.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)			
<i>Burial</i>		<i>3-20-65</i>		<i>Mt. Calvary</i>			<i>Brooklyn, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 18 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR <i>Charles G. Rice</i>			ADDRESS <i>6614 Banne St</i>	

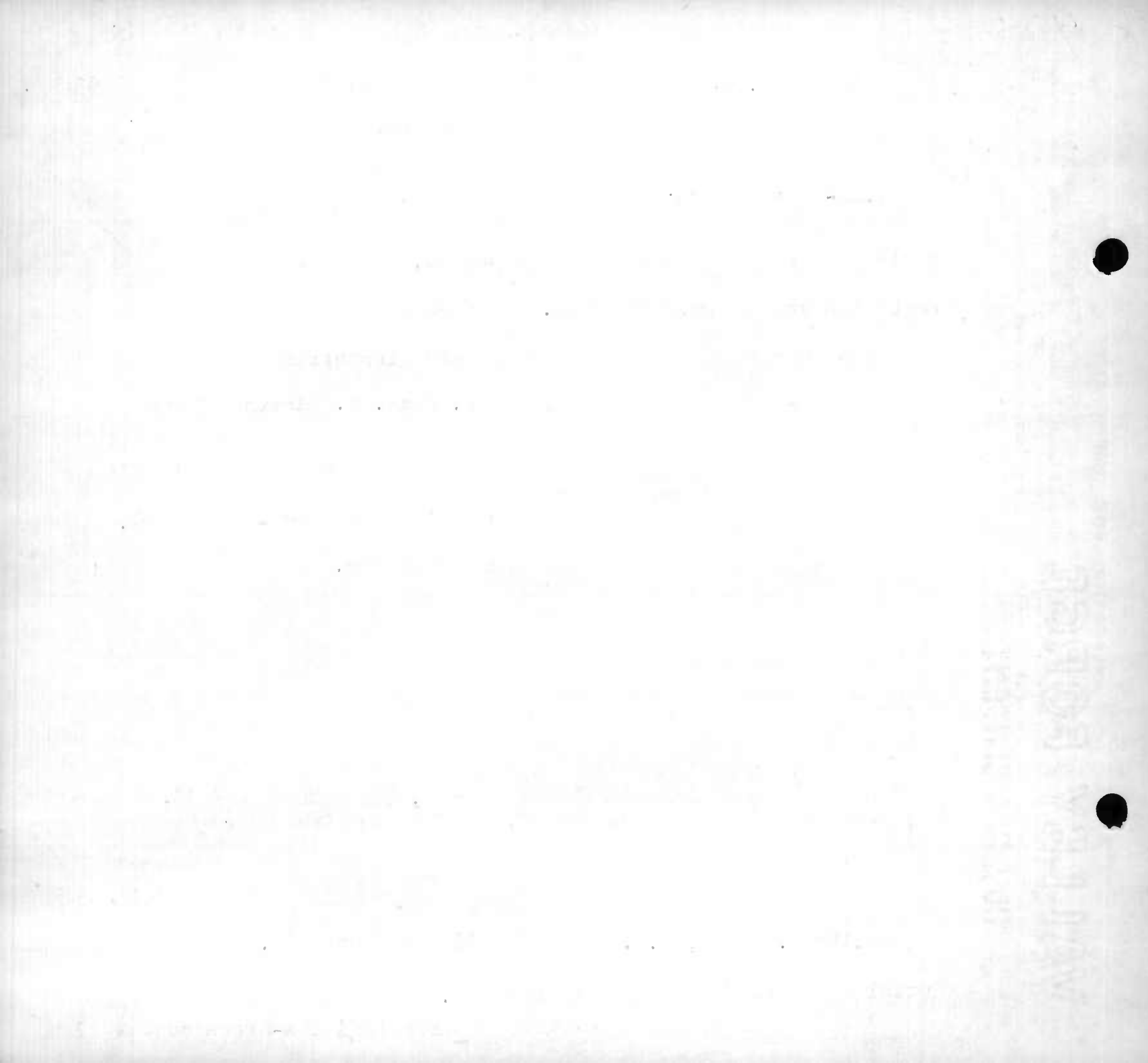




# FUNERAL DIRECTOR: IMPORTANT

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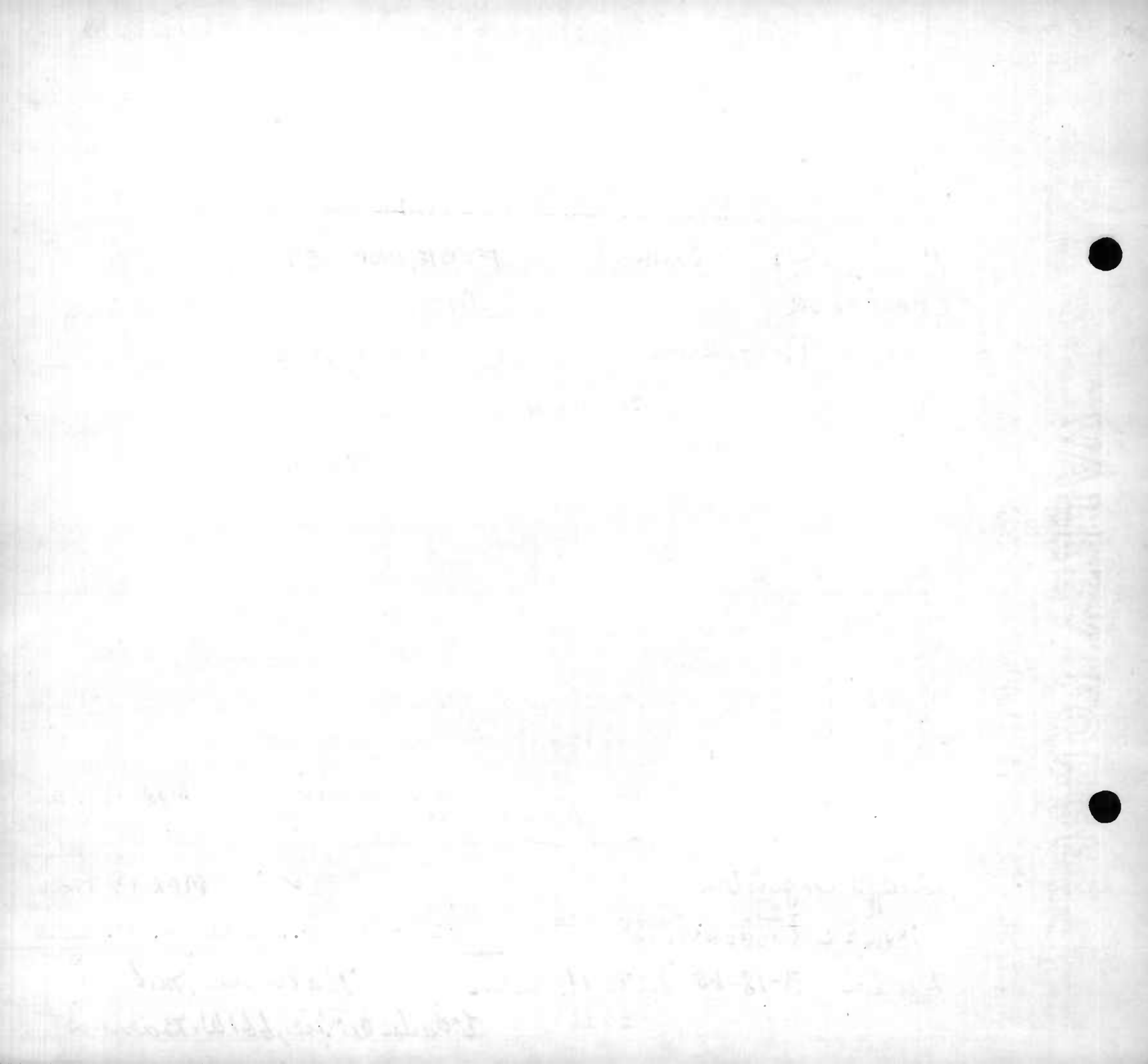
BIRTH NO. 65 2912				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 2912	
1. NAME OF DECEASED (Type or Print) <b>CECELIA E. FLEMING</b>				2. DATE AND HOUR OF DEATH <b>3/16/65</b> <b>10:30A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1106eSherwood Avenue</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-38</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1106 Sherwood Avenue</b>					
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>		8. DATE OF BIRTH <b>May 30, 1885</b>		9. AGE (in years last birthday) <b>79</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Receptionist</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Bradford Apts.</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Ythomas Burns</b>				14. MOTHER'S MAIDEN NAME <b>Mary Fitzpatrick</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Mr. Chas. T. Fleming (Son)</b>			
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Coronary Occlusion</b> DUE TO (B) <b>Arteriosclerotic cardio-</b> DUE TO (C) <b>vascular disease.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>5 yrs.</b>	
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>February 1, 1962</b> to <b>March 16, 1965</b> , that (I) (we) last saw the deceased alive on <b>February 27, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Philip D. Flynn</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>March 17, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Philip D. Flynn, M.D.</b>				23D. ADDRESS <b>11 East Chase St.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/19/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cem</b>		24D. LOCATION (City, town, or county) (State) <b>City</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 18 1965</b>				25B. NAME OF REGISTRAR <i>Robert E. Stuber</i>		25C. FUNERAL DIRECTOR <i>WDEDELD &amp; SON</i>		ADDRESS <b>Greenmount &amp; 22 ND</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2913	
BIRTH NO. 65 2913		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. 65 2913					
1. NAME OF DECEASED (Type or Print) <b>STERLING PATTERSON</b>		2. DATE AND HOUR OF DEATH <b>MAR. 13, 1965 10:30 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MONTEBELLO STATE HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>4-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO. 214 W. Greene St.</b> D. STREET ADDRESS (If rural, give location) <b>THE MISSION ON GREENE ST.</b>			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>DIVORCED</b>	8. DATE OF BIRTH <b>FEB 18, 1906</b>	9. AGE (In years lost birthday) <b>59</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
13. FATHER'S NAME <b>JOHNIE PATTERSON</b>		14. MOTHER'S MAIDEN NAME <b>HENDERSON</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-01-3521</b>		17. INFORMANT ADDRESS	
18. <b>163 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>CARCINOMA OF LUNG</b> DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>18 MOS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>NOV. 16, 1964</b> to <b>MAR. 13, 1965</b> , that <del>it</del> (we) last saw the deceased alive on <b>MAR. 13, 1965</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>It</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Irving L. Cooperstein</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>MAR. 13, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>IRVING L. COOPERSTEIN</b>		23D. ADDRESS <b>2201 Argonne Dr., Baltimore, Md. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-18-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 18 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Robert E. Rice, 661 W. Borne St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 2914	
BIRTH NO. 65 2914		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Mary Richberg</b>		2. DATE AND HOUR OF DEATH <b>March 13, 1965 8:55 A. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
5. SEX <b>Female</b>				6. RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	
8. DATE OF BIRTH <b>5-3-1914</b>		9. AGE (In years last birthday) <b>50</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS <b>RECORDS: BCH 4940 Eastern Avenue 21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>				CAUSE OF DEATH (A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Far Advanced Tuberculosis</b>				(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Carcinoma of Cervix, Stage II</b>				(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>March 2, 1965</b> to <b>March 13, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 13, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>R. Cooke</b>		M.D. <b>Robert Cooke</b>		23B. DATE SIGNED <b>March 13, 1965</b>		23C. PHYSICIAN'S NAME (Type) <b>Robert Cooke</b>	
23D. ADDRESS <b>4940 Eastern Avenue 21224</b>		M.D. <b>Charles A. Rice</b>		23E. FUNERAL DIRECTOR <b>Charles A. Rice, 661 W. T. Barre</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-17-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 18 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Stakeman</b>		25C. FUNERAL DIRECTOR <b>Charles A. Rice, 661 W. T. Barre</b>			





2-130

65 2915

BALTIMORE CITY HEALTH DEPARTMENT

65 2915

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES DEVONE</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>March 16, 1965</b> <b>4:40 p</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>University Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2602 Huron St.</b>			
5. SEX <b>male</b>	6. RACE <b>colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday) <b>46</b>	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wesley Devone</b>				14. MOTHER'S MAIDEN NAME <b>Estello</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Lizzie Williams 2602 Huron St.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>Asphyxia</b> (A) DUE TO  <b>Hanging</b> (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  <b>Partial</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2602 Huron St.</b>			
21D. TIME OF INJURY (APPROX.) <b>3 16 65 11:30 a.m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Hung self</b>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. <b>Rudiger Breitenecker</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>3-17-65</b>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>3/21/65</b>		23C. NAME OF CEMETERY or CREMATORY <b>Garland</b>		23D. LOCATION (City, town, or county) (State) <b>North Carolina</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>MAR 18 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		24C. FUNERAL DIRECTOR ADDRESS <b>Charles A. Rice 661 W. Barre St.</b>			

19650002920

WALLER BOOKS

AMERICAN  
BOOKS  
U.S.A.

Robertson

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2916		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2916	
1. NAME OF DECEASED (Type or Print) <b>SPARROW - WALTER D.</b>			2. DATE AND HOUR OF DEATH <b>3-15-65 11PM 11 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BON SECOUR HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>20-03</b>		
5. SEX <b>M</b>			6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>9-15-97</b>
13. FATHER'S NAME <b>Louis G. SPARROW</b>			11. BIRTHPLACE (State or foreign country) <b>BALTO. - Maryland</b>		9. AGE (In years last birthday) <b>67</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War I</b>			16. SOCIAL SECURITY NO. <b>218-105119</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
17. INFORMANT <b>SON</b>			ADDRESS		
18. <b>434.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>① Congestive Heart Failure (7 years)</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>② Generalized atherosclerosis</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) <b>③ Acute Pulmonary edema</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-15-65</b> 19 <b>65</b> to <b>3-15</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3-15-65</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Agustin del Campo</b> M.D.				23B. DATE SIGNED <b>3-16-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>AGUSTIN DEL CAMPO</b> M.D.				23D. ADDRESS <b>BON SECOURS HOSP. BALT. MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Mar. 19-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. National Cem.</b>	
24D. LOCATION <b>Baltimore City</b>		24E. STATE <b>MD.</b>		24F. CITY, TOWN, OR COUNTY	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 18 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Parker</b>		25C. FUNERAL DIRECTOR <b>Walters Funeral Home - Pratt &amp; Stricker STS.</b>	

Mr. J. H. Smith  
City Health Department  
San Francisco, Cal.  
Dear Sir:  
I am writing you in regard to the  
matter of the health of the  
community.

Very truly yours,  
J. H. Smith  
City Health Department  
San Francisco, Cal.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 2917	
BIRTH NO. 65 2917		CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) <i>Mary S. Williams</i>						2. DATE AND HOUR OF DEATH <i>3-13-65 12:30 P.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>33 Johns Hopkins Hosp</i>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>7-05</i> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Bethesda, Md</i> D. STREET ADDRESS (If rural, give location) <i>1643 E. Madison St</i>					
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>wid</i>	8. DATE OF BIRTH <i>7/8/1908</i>	9. AGE (in years last birthday) <i>56</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>At home</i>			11. BIRTHPLACE (State or foreign country) <i>Chester, S.C.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>SHANNON Richard Dix</i>						14. MOTHER'S MAIDEN NAME <i>NANCY SHANNON</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>215-12-4781</i>			17. INFORMANT <i>Mary Jones</i>			ADDRESS <i>2038 Cecil Ave.</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) <i>Massive Acute Myocardial Infarction</i> DUE TO <i>ASCVD</i> (B) <i>Hypertension</i> DUE TO <i>5 yrs</i> (C) <i>20 yrs</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>2</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>Yes</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>3-13</i> 19 <i>65</i> to <i>3-13</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>3-13</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Richard L. Pigg</i>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>3-13-65</i>		
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-18-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Anne Arundel Co., Md.</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 18 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Talbot</i>			25C. FUNERAL DIRECTOR <i>Randolph J. Collick</i>			ADDRESS <i>1412 E. Preston St.</i>		

1918 25th

St. Stephen's Church, N.Y.

St. Stephen's Church, N.Y.

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St. Stephen's Church, N.Y.

St. Stephen's Church, N.Y.

42-66-70

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2918				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2918	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Felix Sanders				3-15-65 3:50 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				A. STATE B. COUNTY Maryland 8-05			
5. SEX Male				6. RACE Negro			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married				8. DATE OF BIRTH 7-3-05			
9. AGE (In years last birthday) 59				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			
11. BIRTHPLACE (State or foreign country) South Carolina				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Classie Sanders			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 250-32-1027			
17. INFORMANT RECORDS: B.C.H. 4940 Eastern Avenue #21224				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Carcinoma of Lung DUE TO (B) DUE TO (C) DUE TO			
INTERVAL BETWEEN ONSET AND DEATH 1 Year							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION O				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) No				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 1-21-65 to 3-15-65, that (I) (we) last saw the deceased alive on 3-15-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. Cooke				23B. DATE SIGNED 3-15-65			
23C. PHYSICIAN'S NAME (Type) Dr. Robert Cooke				23D. ADDRESS 4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3-20-65			
24C. NAME OF CEMETERY or CREMATORY Carver Memorial Pk. Laurel, Md.				24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 18 1965				25B. NAME OF REGISTRAR R. Cooke			
25C. FUNERAL DIRECTOR R. Cooke				25D. ADDRESS 1412 E. Preston St.			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2919				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2919	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>HARRIET WHITTINGTON</b>			
2. DATE AND HOUR OF DEATH <b>3-16-65</b>				7 <sup>35</sup> / <sup>A</sup> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LUTHERAN HOSPITAL OF MARYLAND</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>15-03</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>				D. STREET ADDRESS (If rural, give location) <b>1629 Moreland Avenue</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>COLORED</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>6-16-02</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cambridge mel</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter Young</b>				14. MOTHER'S MAIDEN NAME <b>Elijee Cornish</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elsie Dyer</b> ADDRESS	
18. <b>5810 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				(A) <b>HEPATIC COMA DUE TO PROBABLY LIVER CIRRHOSIS</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>INTESTINAL HEMORRHAGE</b>			
				(C) <b>PROBABLY ESOPHAGEAL VARICES</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>(N)</del> (this hospital) attended the deceased from <b>3-12-65</b> 19 to <b>3-16-65</b> 19 that <del>(N)</del> (we) last saw the deceased alive on <b>3-16-65</b> 19 and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Bok Soo Kim</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-16-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>BOK SOO KIM</b> <b>BOK SOO KIM</b> M.D.				23D. ADDRESS <b>LUTHERAN HOSPITAL OF MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>3/20/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bethel Cent</b>		24D. LOCATION (City, town, or county) (State) <b>Cambridge mel</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 18 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>E. O. Kilian</b> ADDRESS <b>1000 Brantly Ave</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

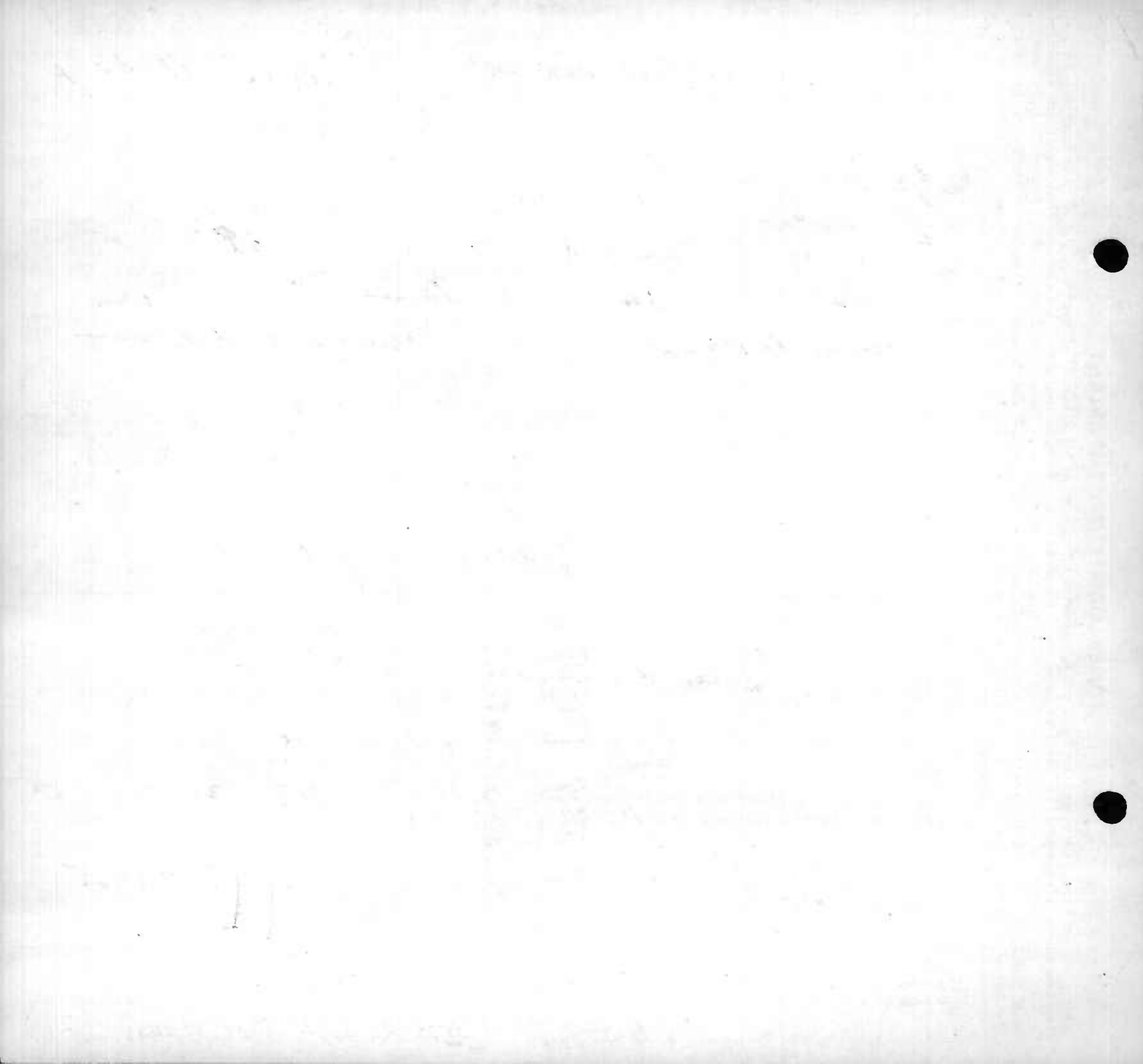
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 2920</span>	
CERTIFICATE OF DEATH					
BIRTH NO. <span style="float: right;">65 2920</span>		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>William Bell</i>		2. DATE AND HOUR OF DEATH <i>March 14, 1965</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>14-03</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>2011 Mc W. Allen St</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>2011 Mc Cullough St</i>			
5. SEX <i>M</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>Jan 1, 1894</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>N. Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Wm H. known</i>			
14. MOTHER'S MAIDEN NAME <i>Wm H. known</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Clara Finney 2011 Mc W. Allen St</i>			
18. <i>420.1</i> I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Coronary Thrombosis</i> <i>One day</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Arteriosclerosis</i> <i>2 years</i>			
		(C) <i>Hypertension</i>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2/9/65</i> 19 to <i>3/14/65</i> 1965, that (I) (we) last saw the deceased alive on <i>3/14/65</i> 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>I. Bradshaw Higgins</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3/15/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>I. Bradshaw Higgins</i>		23D. ADDRESS <i>2243 Madison Ave; Balt. Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <i>3-18-65</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Woodland Cem.</i>		24D. LOCATION (City, town, or County) (State) <i>Washington D.C.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 18 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Higgins</i>		25C. FUNERAL DIRECTOR <i>Elmer Wilson</i>	
				ADDRESS <i>1000 Brantly Ave</i>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>65 2921</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2921</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>HESTER, CATHERINE</b>		2. DATE AND HOUR OF DEATH <b>3.17.65 11:40 A</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Franklin Square Hosp</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 5300</b>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <b>3 Albatross Lane (21)</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>7.18.15</b>	9. AGE (In years last birthday) <b>49</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ho</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Ho</b>		11. BIRTHPLACE (State or foreign country) <b>Penn.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Thomas Gallagher</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Coleman</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Husband (same as above)</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Obstructive jaundice Liver metastases Liver failure</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>Carcinoma of breast</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>3.16.65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Chest Cancer</b>		20A. AUTOPSY? (Yes or No) <b>X</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3.16.65</b> to <b>3.17.65</b> , that (I) (we) lost saw the deceased alive on <b>1040 AM 3.17.65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>F. Speed</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3.17.65</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial &amp; Removal</b>		24B. DATE <b>3/20/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cathedral</b>	
24D. LOCATION (City, town, or county) (State) <b>Scranton, Pa.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 19 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Connelly - 300 Mace (21)</b>	

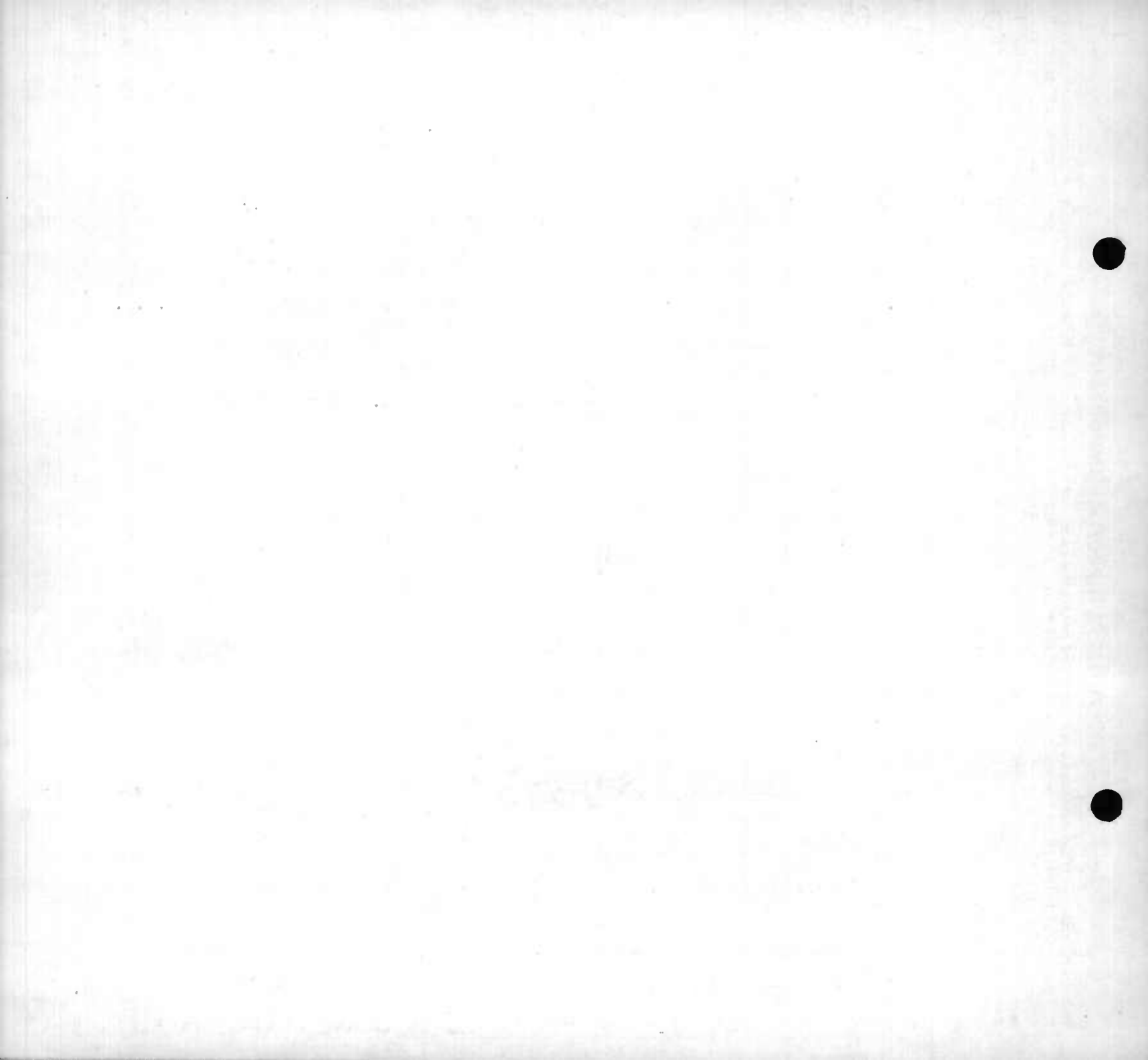




# FUNERAL DIRECTOR: IMPORTANT

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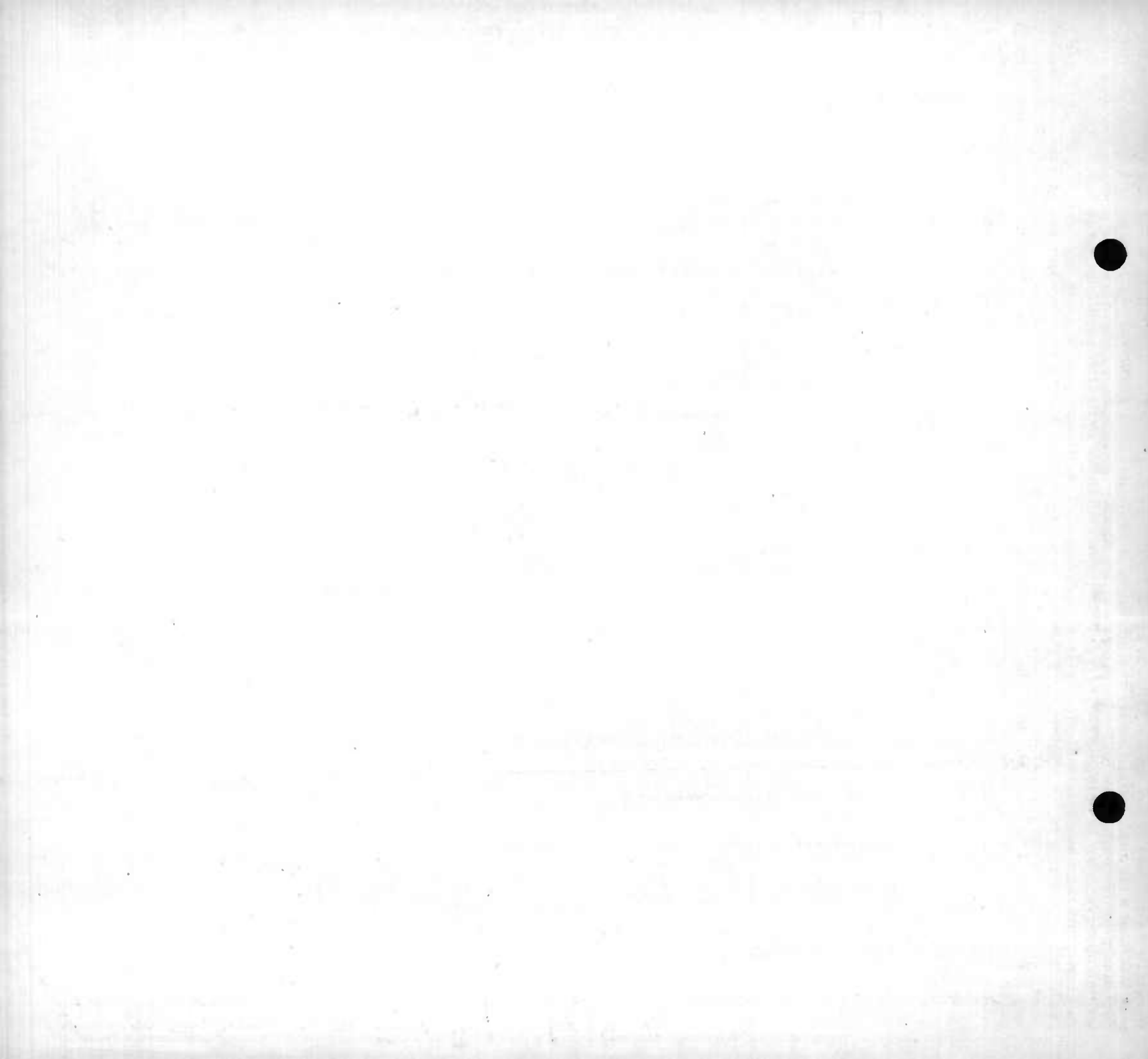
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 2922</span>	
CERTIFICATE OF DEATH					
BIRTH NO. <span style="float: right;">65 2922</span>		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <span style="float: right;">Edward Dorer</span>			2. DATE AND HOUR OF DEATH <span style="float: right;">3-16-1965 6 A. M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="float: right;">4211 Springwood Avenue</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="float: right;">Md.</span> B. COUNTY <span style="float: right;">2601</span>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="float: right;">Baltimore, Md</span>		
			D. STREET ADDRESS (If rural, give location) <span style="float: right;">4211 Springwood Avenue #6</span>		
5. SEX <span style="float: right;">Male</span>	6. RACE <span style="float: right;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="float: right;">Married</span>	8. DATE OF BIRTH <span style="float: right;">3-19-1892</span>	9. AGE (In years last birthday) <span style="float: right;">73</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Ret. Clerk</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">Supervisor Elections</span>		11. BIRTHPLACE (State or foreign country) <span style="float: right;">Baltimore, Maryland</span>	
				12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U.S.A.</span>	
13. FATHER'S NAME <span style="float: right;">Fredrick Dorer</span>			14. MOTHER'S MAIDEN NAME <span style="float: right;">Barbara Unknown</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">No</span>		16. SOCIAL SECURITY NO. <span style="float: right;">212-07-0269</span>		17. INFORMANT ADDRESS <span style="float: right;">Mr Louis E. Dorer 4211 Springwood Avenue</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) <span style="float: right;">Carcinomatous</span> DUE TO (B) <span style="float: right;">Carcinoma of Stomach</span> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <span style="float: right;">3 months</span> <span style="float: right;">8 months</span>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="float: right;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="float: right;">no</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="float: right;">December 19 64</span> to <span style="float: right;">March 16 19 65</span> , that (I) ( <del>was</del> ) last saw the deceased alive on <span style="float: right;">march 15 19 65</span> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <span style="float: right;">Paul B Mueller</span>				23B. DATE SIGNED <span style="float: right;">3/17/65</span>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <span style="float: right;">M.D.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">3-20-1965</span>		24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Loudon Park Cemetery</span>	
				24D. LOCATION (City, town, or county) (State) <span style="float: right;">Baltimore Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">MAR 19 1965</span>		25B. NAME OF REGISTRAR <span style="float: right;">R. E. Stalvey</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="float: right;">1234 2nd Avenue 7401 Belair Road</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2923	
BIRTH NO. 65 2923		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>HARRY A GEOGHEGAN</b>		2. DATE AND HOUR OF DEATH <b>March 15, 1965</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>6447 Bushey St. Balto. 24, Md.</b>		A. STATE <b>Md.</b> B. COUNTY <b>Balto.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Highlandtown</b>			
		D. STREET ADDRESS (If rural, give location) <b>6447 Bushey St. Balto. 24</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>Aug 12, 1885</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>B.Y.C. (Retired)</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Olivier Geoghegan</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Preston</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-10-0358A</b>		17. INFORMANT <b>Son (Same as above)</b>	
18. <b>420.1 I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <b>Myocardial occlusion</b>		<b>20 min</b>	
ANTECEDENT CAUSES		(B) DUE TO <b>Arteriosclerotic heart disease</b>		<b>7 yrs</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Benign Prostatic Hypertrophy</b>	
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 1</b> 1963 to <b>Feb. 15</b> 1965, that (I) (we) last saw the deceased alive on <b>Feb. 15</b> 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Randolph H. Spitzberg M.D.</b>				23B. DATE SIGNED <b>Mar 17, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>RANDOLPH H. SPITZBERG</b>		23D. ADDRESS <b>338 W PRATT ST, BALTIMORE 21201 MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/18/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Parkwood</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 19 1965</b>	25B. NAME OF REGISTRAR <b>R. B. E. Taylor</b>	25C. FUNERAL DIRECTOR <b>Connelly 300 Mace Ave. Balto. 21</b>			



1  
5-530

65 2924

BALTIMORE CITY HEALTH DEPARTMENT

65 2924

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SIDNEY A. SMITH

2. DATE AND HOUR PRONOUNCED DEAD

March 15, 1965

5:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION

SOUTH BALTIMORE GENERAL  
HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

508 Arsan Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 18, 1919

9. AGE (In years  
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Foreman

10B. KIND OF BUSINESS OR INDUSTRY

Chemical Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Sidney Smith

14. MOTHER'S MAIDEN NAME

Henrietta M. Acton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL  
SECURITY NO.

218-03-1800

17. INFORMANT

Mrs. Georgina Smith, 508 Arsan Ave.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular  
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-16-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3-18-1965

23C. NAME OF CEMETERY or CREMATORY

Cedar Hill Cemetery

23D. LOCATION

(City, town, or county)

Ritchie Hwy., A.A. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 19 1965

24B. NAME OF REGISTRAR

Robert E. Farkner

24C. FUNERAL DIRECTOR

George J. Gonce, 4001 Ritchie Hwy.

Baltimore 25, Md.

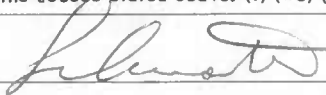


VALLEY FORGE

PAID OFF

*John F. H. H.*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2925</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 2925</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Stephen Gladdin</b>		2. DATE AND HOUR OF DEATH <b>March 16, 1965 10:45 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2301</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>178 W. Hamburg Street 21230</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>6-3-97</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>L</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Produce</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>RECORDS: BCH: 4940 Eastern Avenue #24</b>	
18. <b>331X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <b>Respiratory Arrest</b> DUE TO (B) <b>Cerebrovascular Accident</b> DUE TO (C) <b>Anemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 Minutes</b> <b>1 Month</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>February 26, 1965</b> to <b>March 16, 1965</b> , that (I) (we) lost saw the deceased alive on <b>March 16, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>March 16, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. M. Schuster</b>		23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3022-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore City</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 19 1965</b>			
25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR 			
25D. ADDRESS <b>1 x 8 21 montgomery st</b>					



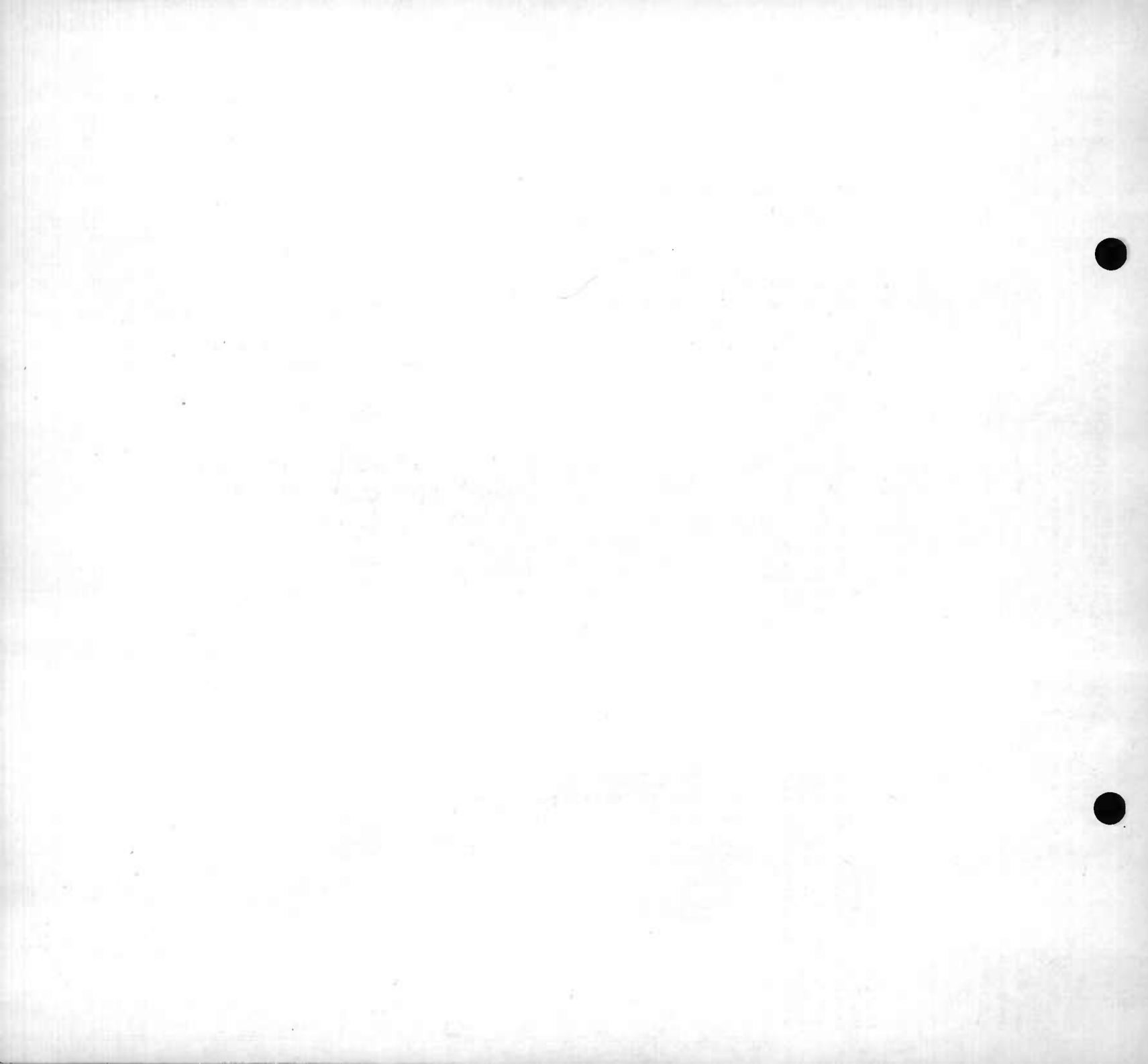
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2926</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2926</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CORRIERI, CHARLES</b>		2. DATE AND HOUR OF DEATH <b>3-17-65 12:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-05</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hosp.</b>		D. STREET ADDRESS (If rural, give location) <b>1723 St. Paul Street</b>			
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>1-20-14</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CAB DRIVER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TAXI CO.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles P. Corriere</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Smith</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W.W. II</b>		16. SOCIAL SECURITY NO. <b>212-12-2427</b>		17. INFORMANT ADDRESS <b>Leonard Corriere - 247 Bolton Rd.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>581.11</b>		CAUSE OF DEATH (A) DUE TO <b>Gastrointestinal hemorrhage from Esophageal varices</b> (B) DUE TO <b>Cirrhosis, alcoholic</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-16-1965</b> to <b>3-17-1965</b> , that (I) (we) lost saw the deceased alive on <b>3-17-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Nabil F. Wansal</b> M.D.				23B. DATE SIGNED <b>3-17-65</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-19-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 19 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Ford's Tavern, Md. 200</b>	



B-520

65 2927

BALTIMORE CITY HEALTH DEPARTMENT

65 2927

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH A. BENNIS

2. DATE AND HOUR PRONOUNCED DEAD

March 17, 1965 5:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

108 E. Madison Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

3/19/08

9. AGE (In years  
last birthday)

56 XX

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Aluminum sider

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MASS

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

SIMON BONITSKI

14. MOTHER'S MAIDEN NAME

CATHERINE USDVINIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

CATHERINE USDVINIS GREENFIELD, MASS.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.) 21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/18/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

3/20/65

23C. NAME of CEMETERY or CREMATORY

CALVARY CEMETERY

23D. LOCATION

(City, town, or county)

(State)

GREENFIELD, MASS

24A. DATE REC'D BY HEALTH DEPT.

MAR 19 1965

24B. NAME OF REGISTRAR

Robert E. Parker, M.D.

24C. FUNERAL DIRECTOR

HOWARD H. HUBBARD

ADDRESS

4107 WILKENS AVE. 21229

7650002932

WALLLEY POLICE

FOR IDENTIFICATION

SECTION THREE

SECTION TWO

SECTION ONE

SECTION FOUR

SECTION FIVE

SECTION SIX

CLARK

SECTION SEVEN

SECTION EIGHT

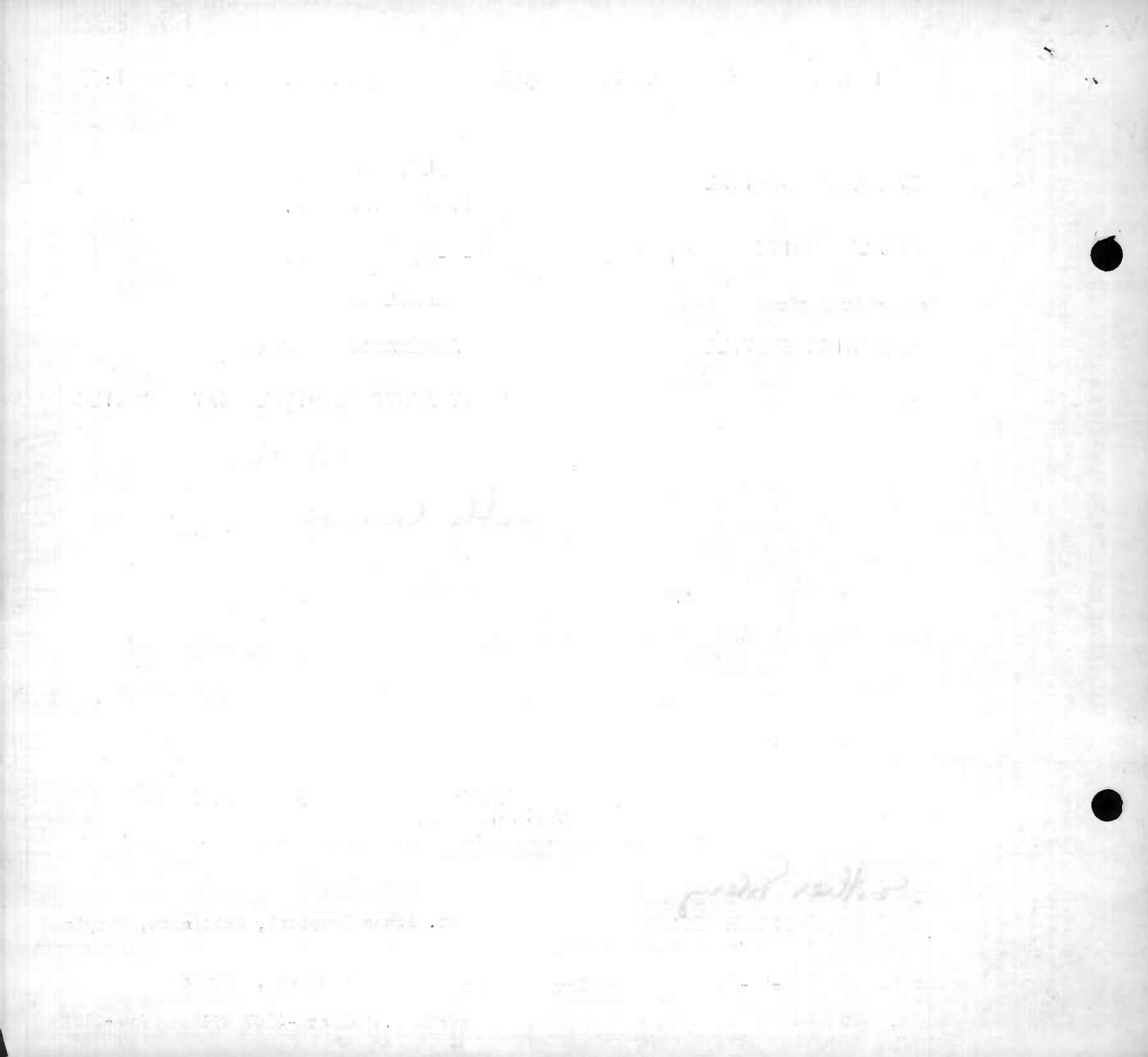
SECTION NINE

SECTION TEN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2928				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2928	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>WIDMYER MARY GRACE</b>				2. DATE AND HOUR OF DEATH <b>MARCH 16 1965 1:55 P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>40 ST AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>21-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1105 BAYARD ST. 21223</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>4-8-93</b>	9. AGE (In years lost birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>FREDERICK SHETTLE</b>				14. MOTHER'S MAIDEN NAME <del>ANNE ROSS</del> <b>Anne Rost</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS AV</b>			
18. <b>13991</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Intestinal obstruction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Possible Carcinoma</b>				CAUSE OF DEATH (A) <b>Intestinal obstruction</b> DUE TO (B) <b>Possible Carcinoma</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 6 1965</b> to <b>MARCH 16 1965</b> that (I) (we) last saw the deceased alive on <b>MARCH 16 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Esther Edery</i> ESTHER EDERY				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>St. Agnes Hospital, Baltimore, Maryland</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-20-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 19 1965</b>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard-4107 Wilkens Ave-21229</b>			

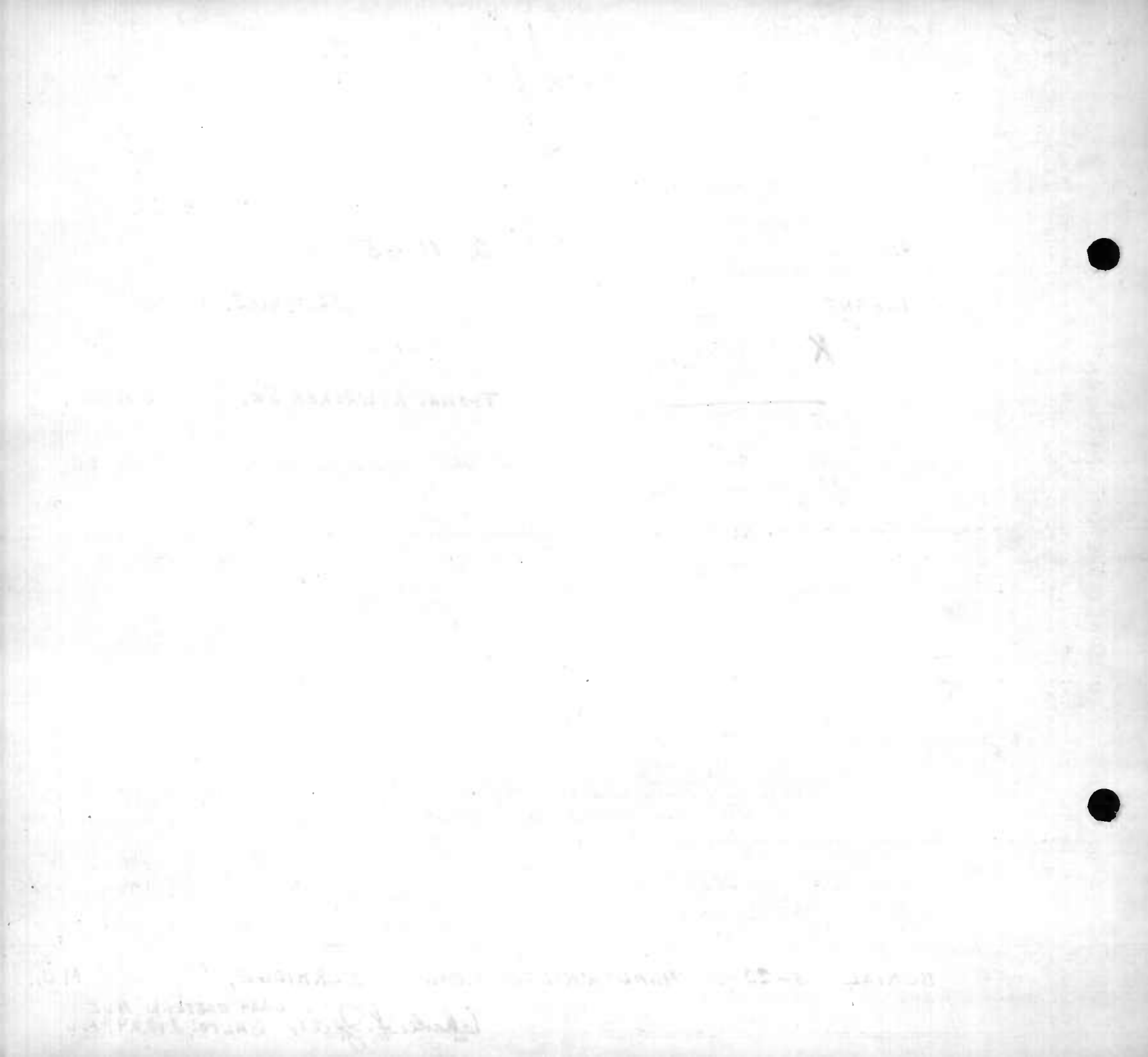




# FUNERAL DIRECTOR: IMPORTANT


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2929		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2929	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) THOMAS KERN WALKER, JR.		MARCH 17, 1965		552 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		A. STATE MARYLAND		B. COUNTY BALTIMORE	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 7426 SCHOOL LANE #22			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 2-11-65	9. AGE (in years lost birthday) 4 weeks	If Under 1 Yr. Months Days 1 6
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND, BALTIMORE	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME THOMAS K. WALKER, SR.		14. MOTHER'S MAIDEN NAME LINDA PRICE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT THOMAS K. WALKER, SR.	
				ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) BILATERAL HYDRONEPHROSIS DUE TO (B) SEPTICEMIA DUE TO (C) CONGENITAL ABSENCE OF THE ANUS & CONGENITAL POSTERIOR URETHRAL VALVES		INTERVAL BETWEEN ONSET AND DEATH 4 WEEKS  4 WEEKS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 3/12/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BLADDER OBSTRUCTION		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (it) (this hospital) attended the deceased from MARCH 5 1965 to MARCH 17 1965, that (it) (we) last saw the deceased alive on MARCH 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (it) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth E. Mott		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED MARCH 17, 1965	
23C. PHYSICIAN'S NAME (Type) KENNETH E. MOTT		23D. ADDRESS M.D. UNIVERSITY HOSPITAL BALTIMORE MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 3-20-65	24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE CEM.		24D. LOCATION (City, town, or county) (State) ELKRIDGE, MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 19 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles J. Jiles	
				ADDRESS 6224 EASTERN AVE. BALTO, 21224, MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2930		CERTIFICATE OF DEATH		Registered No. 65 2930		
1. NAME OF DECEASED (Type or Print) <b>Arthur E. Adams</b>				2. DATE AND HOUR OF DEATH <b>March 17, 1965</b>   <b>7:15</b> <b>A. M.</b>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>RURAL</b> D. STREET ADDRESS (If rural, give location) <b>2815 Pennsylvania Avenue 21227</b>						
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>Married Widowed</b>	8. DATE OF BIRTH <b>10-13-01</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>John H. Adams</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Gregg</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>271-12-7994</b>		17. INFORMANT <b>RECORDS: BCH: 4940 Eastern Avenue #24</b>				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Subarachnoid Hemorrhages</b>				(A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>Sept. 1964</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>Hypertension</b>				Years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <b>March 11,</b> 19 <b>65</b> to <b>March 17,</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>March 17,</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE  M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>March 17, 1965</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. M. Schuster</b>				23D. ADDRESS M.D. <b>4940 Eastern Avenue Baltimore, Maryland #24</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/20/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Wilkens Avenue, Balto., Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 19 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Staley</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b> , 4107 Wilkens Ave. # 29						



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2931		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2931	
M.E. CASE NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) VIOLA C. TOFT		2. DATE AND HOUR OF DEATH 3/16/65 1:55 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSP. OF MD.		A. STATE MARYLAND		B. COUNTY AG	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE Pasadena			
		D. STREET ADDRESS (If rural, give location) 10 HOLLY ROAD 5200			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WID.	8. DATE OF BIRTH 6-3-86	9. AGE (In years last birthday) 78	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William C. Griffith		14. MOTHER'S MAIDEN NAME Sally Jackson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Family	
				ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) II PULMONARY EMPHYSEMA CHRONIC BRONCHITIS & COR PULMONALE		CAUSE OF DEATH (A) DUE TO INTESTINAL OBSTRUCTION - ACUTE CAUSE, UNDETERMINED (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-14 1965 to 3-16 1965, that (I) (we) last saw the deceased alive on 3-16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Renato R. Espina		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/16/65	
23C. PHYSICIAN'S NAME (Type) RENATO R. ESPINA		23D. ADDRESS LUTHERAN HOSPITAL OF MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3-20-65	24C. NAME OF CEMETERY or CREMATORY Leder Hill Cem		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 19 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR 2377 Calver Ave	

LEWIS A. JAMES  
KENNETH R. ESTER

LUTHERAN HOSPITAL OF ME

3-16 3-14 3-16 3-16 3-16

CHRONIC BRONCHITIS & EAR PLUMPS  
PULMONARY EMPHYSEMA

CAUSE, UNDETERMINED  
[INTESTINAL OBSTRUCTION - ADULT]

USA

U-3-26 78

F W MID

10 HALL 1000

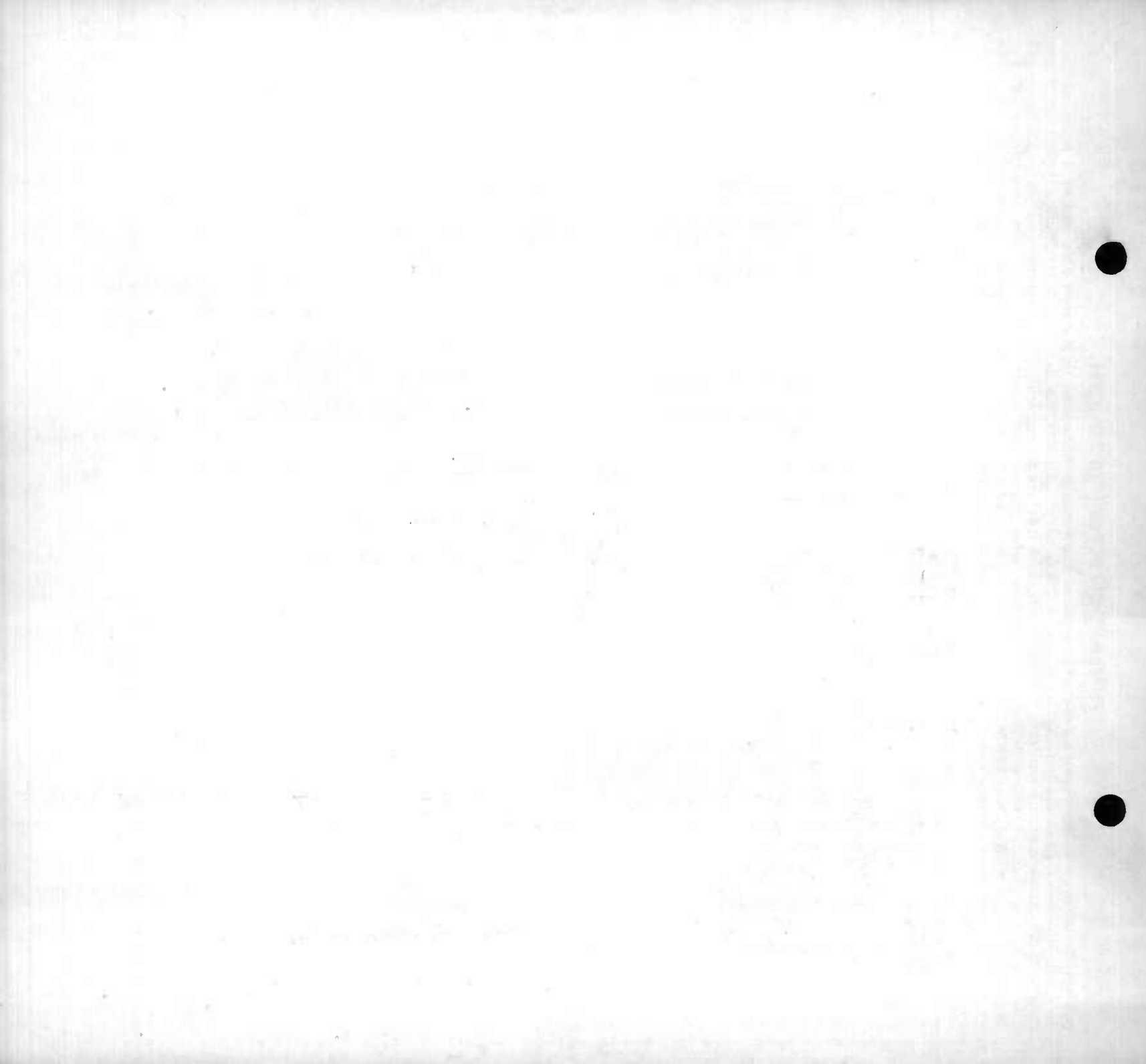
COTTON, FINE 25 100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2932		CERTIFICATE OF DEATH		Registered No. 65 2932	
1. NAME OF DECEASED (Type or Print) <b>Robert Simpson</b>						2. DATE AND HOUR OF DEATH <b>March 15, 1965 12: A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>George Washington Carver Nursing Home</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-06</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3113 Leeds Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb 14, 1881</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butler</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>		11. BIRTHPLACE (State or foreign country) <b>Howard County, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
13. FATHER'S NAME <b>Henry Simpson</b>						14. MOTHER'S MAIDEN NAME <b>Ella Rawlings</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>3041 N. 26th St</b> <b>Mr. Andrew Simpson Phila, Pa</b>				
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <del>Heart</del> <b>Bronchopneumonia</b> DUE TO (B) <b>Hypertension Card. Vasc. Dis.</b> DUE TO (C) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>Unknown</b> <b>Unknown</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 24, 1964</b> to <b>March 15, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 12, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>E. E. Holt</b>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/17/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. E. Holt</b>						23D. ADDRESS M.D. <b>3715 Liberty Hts. Ave.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/18/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Western Star Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Catonsville Balto Co. Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 19 1965</b>			25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>			25C. FUNERAL DIRECTOR ADDRESS <b>Herbert B. Muttter 3035 W. North Ave</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

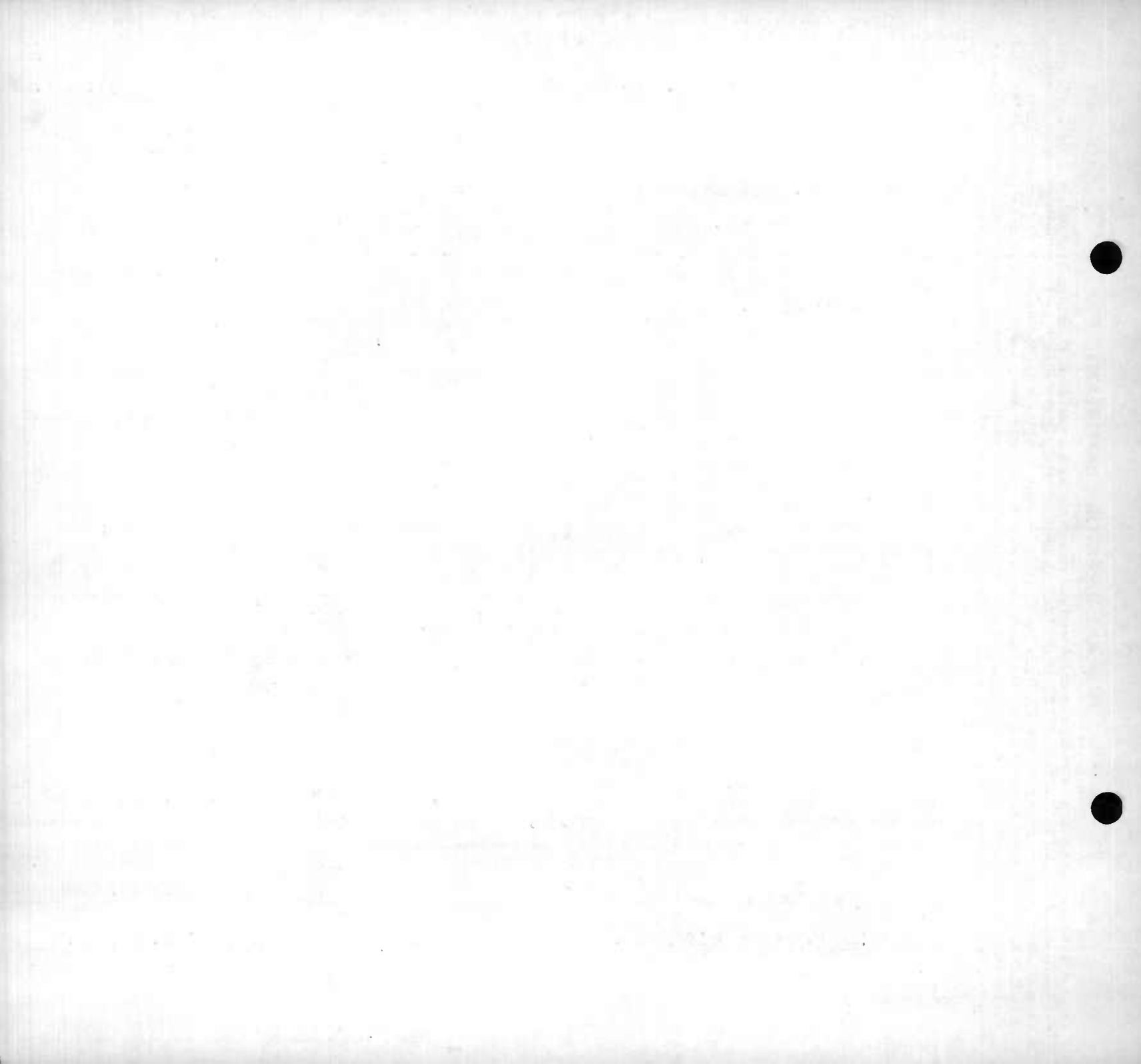
BIRTH NO. 65 2933		BALTIMORE CITY HEALTH DEPT.		Registered No. 65 2933	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Thomas A. Jones		Maryland 17, 1965		1:15 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		RURAL		03-00	
		D. STREET ADDRESS (If rural, give location)			
		7019 Dunbar Road 21222			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	If Under 1 Yr. Months Days Hours Min.
Male	White	Single	5-29-21	43	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Machinist		Can Co.		Virginia	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U. S. A.		Nathaniel L. Jones		Ida Sandridge	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		WW 2 225-18-6965		RECORDS: BCH: 4940 Eastern Avenue #24	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Cardiac Arrest DUE TO		30 Min.	
		(B) Acute Myocardial Infarct DUE TO		4 hrs.	
		(C) Arteriosclerotic Cardio Vascular Disease DUE TO		Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 16, 1965 to March 17, 1965, that (I) (we) last saw the deceased alive on March 17, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Dr. C. Robert Cooke				March 17, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. C. Robert Cooke		4940 Eastern Avenue Baltimore, Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	3/20/65	Mountain Plain Cemetery	Mechum, Virginia		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
MAR 19 1965	Robert E. Taylor	Allrich Funeral Home Dundalk, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 2934		BIRTH NO. 65 2934		CERTIFICATE OF DEATH		Registered No.				
1. NAME OF DECEASED (Type or Print) <b>Grafton, Mr. Burlin Alfred</b>						2. DATE AND HOUR OF DEATH <b>March 13, 1965 11:30 a.m.</b>								
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Joseph Hospital</b>						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2603</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3425 Juneway</b>								
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED <b>Married</b>		8. DATE OF BIRTH <b>5-12-1908</b>		9. AGE (In years last birthday) <b>56</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bethlehem Steel Co.</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>Alfred Grafton</b>						14. MOTHER'S MAIDEN NAME <b>Mazie Gaither</b>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Elizabeth Grafton 3425 Junway</b>			ADDRESS					
18. <b>420.14153.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH					
						(A) <b>Old and fresh posterior myocardial infarct.</b>								
						(B) DUE TO								
(C)														
II						Carcinoma of hepatic flexure of colon; metastasis of liver.								
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?								
22. I certify that (I) (this hospital) attended the deceased from <b>March 13, 1965</b> to <b>March 13, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 13, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <b>William B. Vande Grift, M.D.</b>						23B. DATE SIGNED <b>March 13, 1965</b>								
23C. PHYSICIAN'S NAME (Type) <b>William B. Vande Grift, M.D.</b>						23D. ADDRESS <b>1400 N. Caroline Street, Balto. 13, Md.</b>								
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>March 16/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>								
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 19 1965</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Ulrich Funeral Home</b>			ADDRESS <b>4210 Belair Road</b>					



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>65 2935</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 2935</b>	
1. NAME OF DECEASED (Type or Print) <b>Fletcher Russell</b>			2. DATE AND HOUR OF DEATH <b>March 15, 1965 1:30a.m.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital 1514 Division Street Baltimore, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>13 02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2233 Eutaw Place</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Divorced</b>	8. DATE OF BIRTH <b>2-3-?</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>William Russell</b>			14. MOTHER'S MAIDEN NAME <b>Agnes Russell</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Cynthia Thomas 2430 Eutaw Place</b>	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Cerebral Hemorrhage</b> DUE TO (B) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 9, 1965</b> to <b>March 15, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 15, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Sean A. Line</i> M.D. <b>SEAN A. LINE</b>				23B. DATE SIGNED <b>March 15, 1965</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>1514 Division Street</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-18-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 19 1965</b>			
25B. NAME OF REGISTRAR <i>Charles E. Sullivan</i>		25C. FUNERAL DIRECTOR <i>Frances A. Hemaley</i> <b>(Mrs) Frances A. Hemaley</b>			
25D. ADDRESS <b>578 Biddle St</b>					

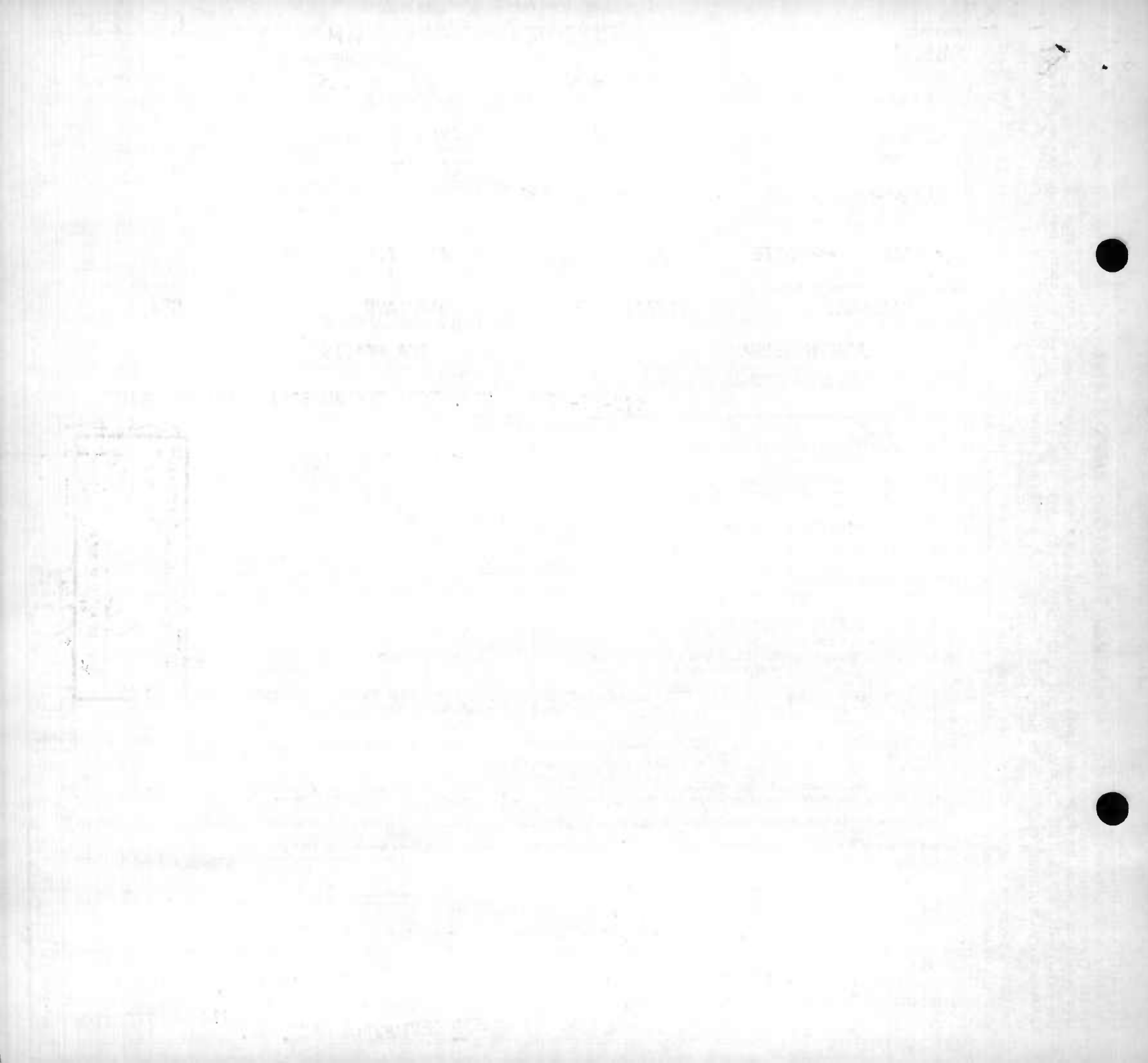




# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2936				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2936	
M.E. CASE NO. 65 2936				1. NAME OF DECEASED (Type or Print) SAMUEL BERMAN		2. DATE AND HOUR OF DEATH 3/15/65 11:44 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
SINAI HOSPITAL OF BALTO.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 15-11	
				D. STREET ADDRESS (If rural, give location)		3751 Columbus Drive	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4/19/1909	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SALESMAN		RETAIL SHOES		MARYLAND		USA	
13. FATHER'S NAME JOSEPH BERMAN				14. MOTHER'S MAIDEN NAME IDA GRADIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		212-01-0799		MRS. TOBA BERMAN 3751 COLUMBUS DRIVE			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN DEATH AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO Myocardial Infarction		<div style="border: 1px solid black; padding: 5px;"> <p>A MEDICAL EXAMINER'S CASE</p> <p>Chad J. M.D.</p> <p>CHIEF OR ASST. MEDICAL EXAMINER</p> <p>3/17/65</p> </div>	
ANTECEDENT CAUSES				(B) DUE TO ASCVD			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Inotify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED (Specify)		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 3/15/65 to 3/15/65 that (I) (we) last saw the deceased alive on 3/15/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Gerardo M. Yipil				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/16/65	
23C. PHYSICIAN'S NAME (Type) GERARDO M. YPIL				23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/17/65		24C. NAME of CEMETERY or CREMATORY BETH EL MEMORIAL PARK		24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 19 1965		25B. NAME OF REGISTRAR Robert E. Starkey		25C. FUNERAL DIRECTOR ADDRESS SOD LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

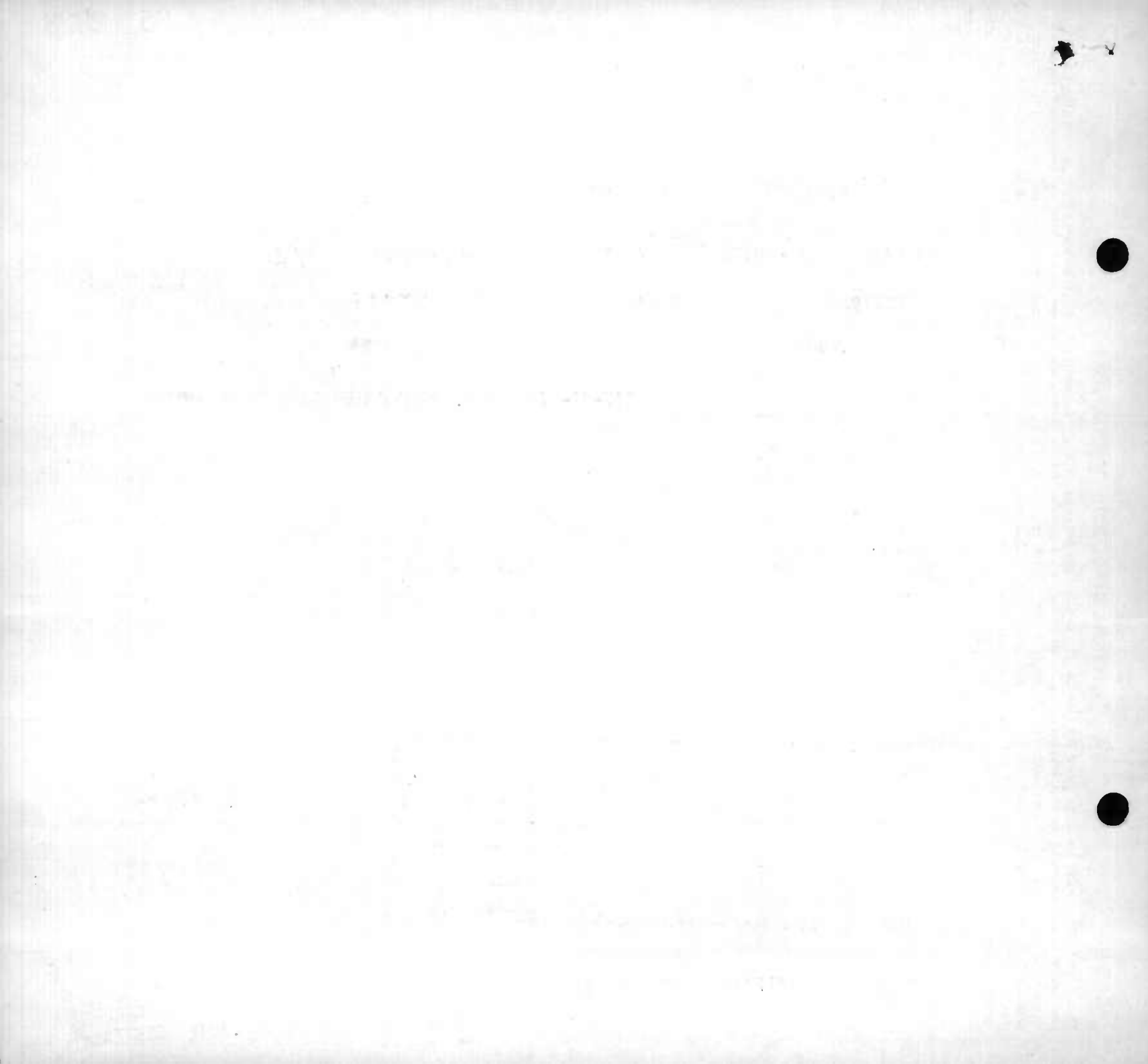
BIRTH NO. 65 2937				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2937	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JACOB RAVEN				2. DATE AND HOUR OF DEATH MARCH 15, 1965 10:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) PALL MALL NURSING HOME 4601 PALL MALL ROAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 15-12 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2825 HILL DALE AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday) 76	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY MERCHANT		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT ADDRESS MRS. FANNIE RAVEN 2825 HILLDALE AVE			
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Cerebro Vascular Accident - Thrombosis DUE TO (B) Arteriosclerotic Cardio-Vascular Renal Disease DUE TO (C) Diabetes Mellitus.		INTERVAL BETWEEN ONSET AND DEATH 3 days ? ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 10 1965 to Mar 15 1965, that (I) (we) last saw the deceased alive on Mar 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph S. Blum				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/15/65	
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM M.D.				23D. ADDRESS 1115 N. Calver St			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/16/65		24C. NAME OF CEMETERY or CREMATORY BETH ISAAC ADATH ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 19 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SOLLEVINSON & BROS. INC. 6010 REISTERSTOWN RD			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2938		CERTIFICATE OF DEATH		Registered No. 65 2938	
1. NAME OF DECEASED (Type or Print) <b>COHEN-GILBERT</b>				2. DATE AND HOUR OF DEATH <b>3/17/65 1:50 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI-HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>27-18</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>5444 PRICE-AVE-#15</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>4/20/92</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TAILOR</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-01-0185</b>		17. INFORMANT ADDRESS <b>MRS. ROSE COHEN 5444 PRICE AVENUE</b>					
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE-PULMONARY-EDEMA</b>				CAUSE OF DEATH (A) <b>ACUTE-PULMONARY-EDEMA</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1.30 hours</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ACUTE-ANTERIOR-M-I-</b>				(B) <b>ACUTE-ANTERIOR-M-I-</b> DUE TO		<b>72 hours</b>			
				(C) <b>ASCVD-</b>		<b>-?</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>3/14/65</b> 19 to <b>3/17/65</b> 19, that (I) (we) last saw the deceased alive on <b>3/17/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Arón Ary</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> <b>A. ARY</b>		23B. DATE SIGNED <b>3/17/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>ARON-ARY</b>				23D. ADDRESS <b>SINAI-HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3/17/65</b>		24C. NAME of CEMETERY or CREMATORY <b>SHAAREI ZION</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 19 1965</b>		25B. NAME OF REGISTRAR <b>Robert S. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOI LEVINSON &amp; BROS INC. 6010 REISTERSTOWN RD</b>					



B-650

65 2939

BALTIMORE CITY HEALTH DEPARTMENT

65 2939

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DAISY I. BROWN

2. DATE AND HOUR PRONOUNCED DEAD

March 17, 1965 9:25 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1321 Whatcoat Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

June 16, 1898

9. AGE (In years last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Gladys Brown 3306 Clifton Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive and Arteriosclerotic  
Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED  
3/18/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

3/20/65

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 19 1965

24B. NAME OF REGISTRAR

Robert E. Farkley, M.D.

24C. FUNERAL DIRECTOR

George A. Kylan 1348 N. Calhoun St

ADDRESS

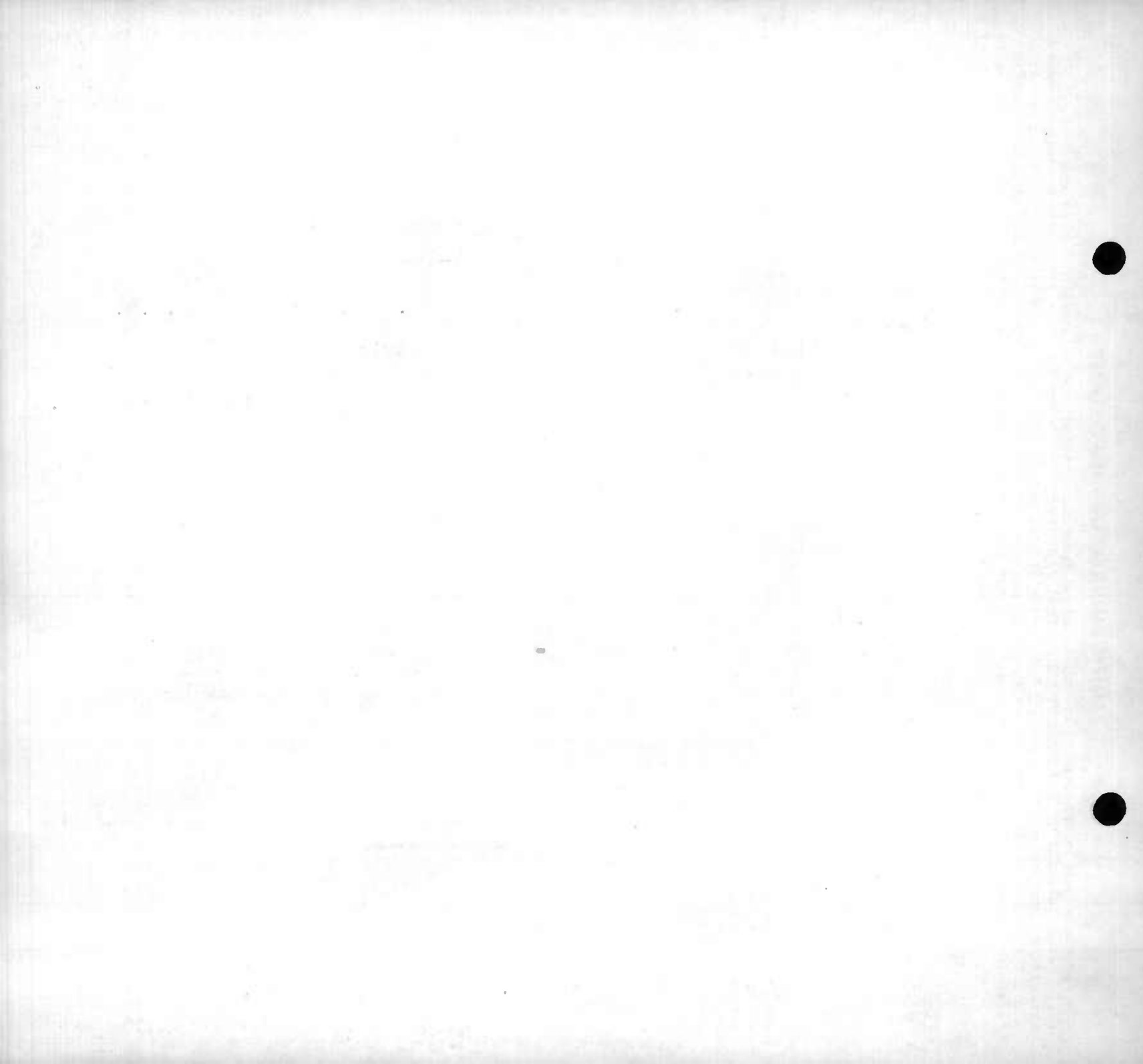


WALLER  
PITTS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

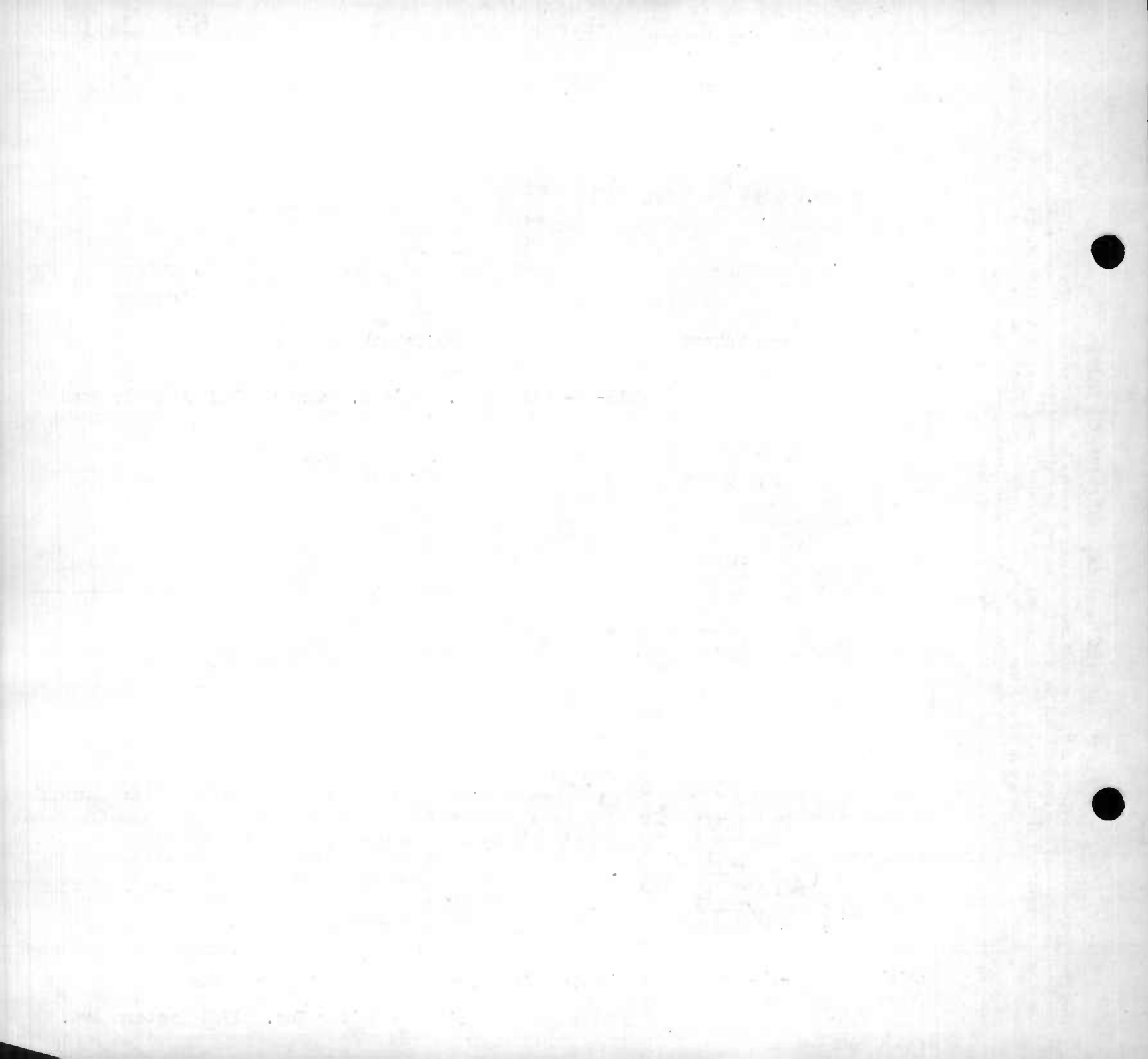
BIRTH NO. 65 2940		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2940	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lynn Alston		2. DATE AND HOUR OF DEATH 3/17/65 5:30P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  Provident Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 16-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2913 Presstman Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-26-04	9. AGE (In years lost birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Dallas		14. MOTHER'S MAIDEN NAME Mary Davis	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT William Alston 2913 Presstman St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cerebral Hemorrhage Hypertensive Cardio-Vascular Disease		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 0			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] 23C. PHYSICIAN'S NAME (Type) M.D.		23B. DATE SIGNED 3/17/65 M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/65		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem.	
24D. LOCATION Baltimore, Maryland		24E. NAME OF REGISTRAR [Signature]		24F. FUNERAL DIRECTOR [Signature]	
24G. DATE REC'D BY HEALTH DEPT. MAR 19 1965		24H. NAME OF REGISTRAR [Signature]		24I. FUNERAL DIRECTOR [Signature]	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 2941		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2941	
M.E. CASE NO.		(Katherine Bogner)		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		BOGNER, KATHLEEN		2. DATE AND HOUR OF DEATH March 18, 1965 4:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		(If not in hospital or institution, give street address or location)		B. COUNTY Baltimore	
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
8. DATE OF BIRTH 4-17-77		9. AGE (In years last birthday) 87		10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hungary	
12. CITIZEN OF WHAT COUNTRY? Hungary		13. FATHER'S NAME George Takacs		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-3279		17. INFORMANT Mrs. Louis J. Wagner	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Myocardial Infarction with Acute Pulmonary Edema (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. MEDICAL CERTIFICATION		20. SIGNATURE Jimmy P. Cordero		21. DATE SIGNED March 18, 1965	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 18, 1965 to March 18, 1965, that (I) (we) last saw the deceased alive on March 18, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Jimmy P. Cordero		23B. DATE SIGNED March 18, 1965	
23C. PHYSICIAN'S NAME (Type) Jimmy P. Cordero		23D. ADDRESS 1400 N. Caroline Street - 21213		24. LOCATION (City, town, or county) (State) Belair, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-22-1965		24C. NAME of CEMETERY or CREMATORY Bel Air Memorial Gardens	
25A. DATE REC'D BY HEALTH DEPT. MAR 19 1965		25B. NAME OF REGISTRAR Lilly & Zeiler Inc.		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901 Eastern Ave.	



BIRTH NO.

65 2942

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 2942

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HORACE OLIVER LONG

2. DATE AND HOUR PRONOUNCED DEAD

March 17, 1965

4: 20 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Church Home &amp; Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

421 S. Chapel St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 15, 1922

9. AGE (In years  
last birthday)

43

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Deck Hand

10B. KIND OF BUSINESS OR INDUSTRY

Baker &amp; Whitley Towing

11. BIRTHPLACE (State or foreign country)

Wilmington, N. C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Isaac P. Long

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

10-27-42

10-16-45

16. SOCIAL  
SECURITY NO.

237-28-5568

17. INFORMANT

ADDRESS

Mrs. Bernadine Long 421 S. Chapel St.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic  
disease

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
3-17-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3-22-1965

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 19 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Lilly &amp; Zeiler Inc.

ADDRESS

1901 Eastern Ave.

WALLEY, POLICE

THE COUNTY

Montgomery



1  
P 621

65 2943

BALTIMORE CITY HEALTH DEPARTMENT

65 2943

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LEANDER PRESBURY

2. DATE AND HOUR PRONOUNCED DEAD

March 17, 1965

10:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2214 Aiken St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2214 Aiken St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

6-10-1917

9. AGE (In years  
lost birthday)

46

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILBERT PRESBURY

14. MOTHER'S MAIDEN NAME

EDNA JONES

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown; If yes, give war or dates of service)

YES W. WAR 2

16. SOCIAL  
SECURITY NO.

219-07-8929

17. INFORMANT

ADDRESS

737 MCCABE AVE. - EDNA PRESBURY

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Bronchopneumonia

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

Cirrhosis of the liver

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Partial

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-17-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

3-22-65

23C. NAME of CEMETERY or CREMATORY

BALTIMORE NATIONAL

23D. LOCATION

(City, town, or county)

BALTIMORE MD

24A. DATE REC'D BY HEALTH DEPT.

MAR 19 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

JOSEPH H. KNIGHT 1639 N. BROADWAY

ADDRESS

*[Handwritten signature]*

65 2944		BALTIMORE CITY HEALTH DEPARTMENT		65 2944	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
ELSIE WILKERSON (McBride)			March 16, 1965 11:40 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland B. COUNTY		
Church Home & Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			10 S. Bond St.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
female	colored		2/7/	35	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Arthur Hayes			Estelle Parker		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Arthur Hayes 20 S. Bond St.	
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
(A) Hypertensive cardiovascular disease					
(B) DUE TO					
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
Obesity					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Rudiger Breiteneker		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial		3/20/65		Mt Auburn	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
MAR 19 1965		Charles E. Jenkins		Charles A. Rice 661 W. Barre St.	

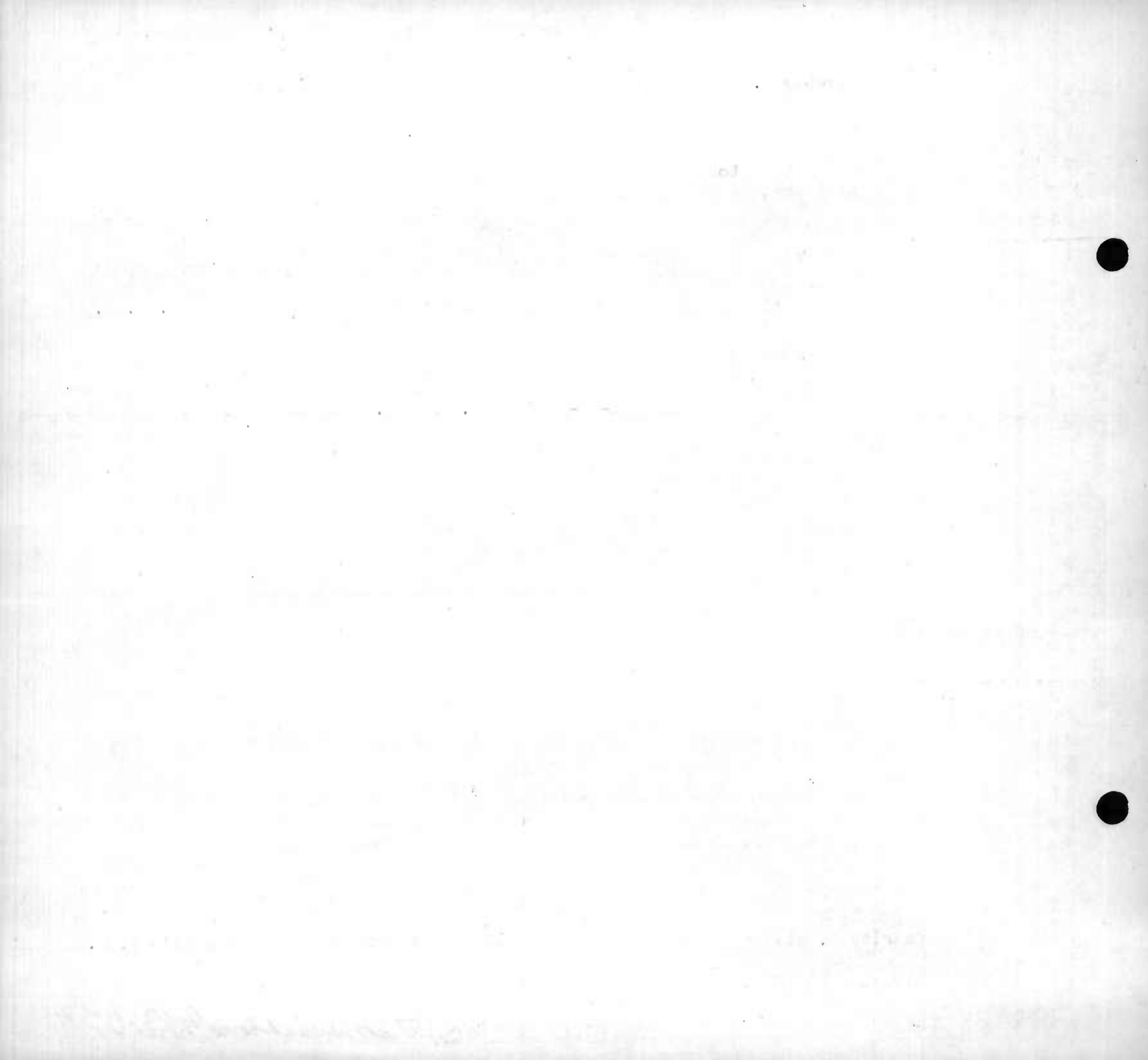
WALLEY P. RINGE

W. R. RINGE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

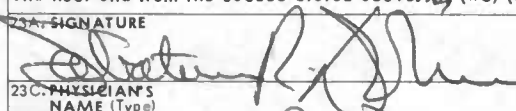
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2945</u>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>65 2945</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>M.E. CASE NO.</b> 1. NAME OF DECEASED (Type or Print) <u>Denis Coleman</u>			2. DATE AND HOUR OF DEATH <u>March 17, 1965</u> <u>5:45 P</u> M.		
3. PLACE OF DEATH IN BALT. CORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>4902 Reisterstown Road</u> <u>Baltimore, Maryland 21215</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>28-31</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4902 Reisterstown Road</u> <u>21215</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>4/27/1898</u>	9. AGE (In years lost birthday) <u>66</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Retired</u>			11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>? Coleman</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>			16. SOCIAL SECURITY NO. <u>031-03-0882</u>		17. INFORMANT <u>Mr. John D. Coleman</u> <u>Marlton, New Jersey</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>422, 114322-11</u> <u>Emphysema</u> (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Wheezing, duodenal</u> (B) DUE TO <u>Arteriosclerotic C.V.D.</u> (C) DUE TO			ADDRESS <u>44 Radnor Boulevard</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Alcoholism, chronic</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>55</u> to <u>March</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>16 March</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles H. Williams</u>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>18 March '65</u>
23C. PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>			M.D. ADDRESS <u>1632 Reisterstown Road Pikesville 8, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/20/1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 19 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Wm. J. Taylor and Sons</u>	
				ADDRESS <u>Baltimore, Md. 21217</u>	



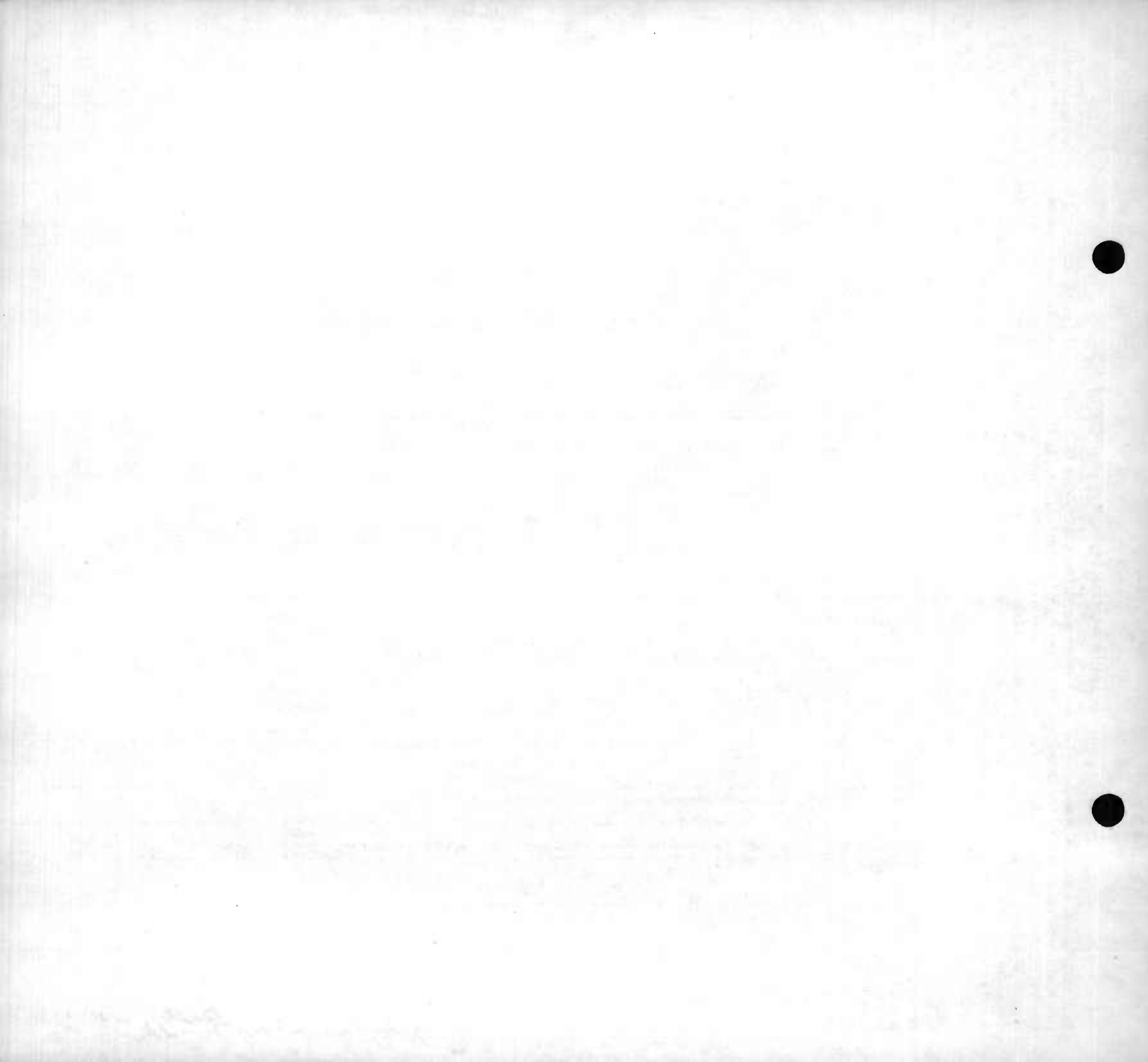


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2946		CERTIFICATE OF DEATH		Registered No. 65 2946	
1. NAME OF DECEASED (Type or Print) <b>WILLIAM RIELLY</b>				2. DATE AND HOUR OF DEATH <b>3-11-65</b> <b>11:20 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MERCY HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>3-11</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1505 E. BALTIMORE ST.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>1/1/86</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>EXTENSIVE BILATERAL Lobar PNEUMONIA (PROBABLY PNEUMOCOCCAL)</b> ANTECEDENT CAUSES <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH CONGESTIVE HEART FAILURE</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <del>this</del> (this hospital) attended the deceased from <b>3-7</b> 19 <b>65</b> to <b>3-11</b> 19 <b>65</b> , that <del>we</del> (we) last saw the deceased alive on <b>3-11</b> 19 <b>65</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>My</del> (We) (did) <del>view</del> view the body after death.									
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-11-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>SALVATORE R. DONOHUE</b>				23D. ADDRESS M.D. <b>MERCY HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/19/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacared Heart</b>		24D. LOCATION (City, town, or county) (State) <b>Dundalk, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 19 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Jenkins</b>		ADDRESS <b>Balto. Md. 21217</b>			





BIRTH NO.

M.E. CASE NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

UNKNOWN BABY GIRL

2. DATE AND HOUR PRONOUNCED DEAD

February 27, 1965 12:33 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Found 1820 Whitmore St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Found 1820 Whitmore St.

5. SEX

female

6. RACE

colored?

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

Newborn

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Probable asphyxia shortly after  
DUE TO birth.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

?

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

Unknown

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

?

?

65

?

21E. INJURY OCCURRED

m. WHILE AT WORK ? NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Unknown

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
2-28-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremated

23B. DATE

3/15/65

23C. NAME of CEMETERY or CREMATORY

Medical Examiner's Office

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 19 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 2948	
BIRTH NO. 65 2948		CERTIFICATE OF DEATH		Registered No. 65 2948	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MALITSOFF, MICHAEL		2. DATE AND HOUR OF DEATH 3/17/65 8:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL		D. STREET ADDRESS (If rural, give location) 11 N. Kenwood Ave #24			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8/17/1907	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME THOMAS MALITSOFF		14. MOTHER'S MAIDEN NAME ANNA ILEONA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-16-6808		17. INFORMANT Mrs. Alice M. Tucker 11 N. Kenwood Ave	
18. 193.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Astrocytoma Grade III. in the right occipitoparietal region. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Beginning 7 January 1965	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2-1-1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED For brain tumor		20A. AUTOPSY? (Yes or No) YES-PARTIAL	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-1-1965 to 3-17-1965, that (I) (we) last saw the deceased alive on 3-17-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sumio Uematsu M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 3-17-1965	
23C. PHYSICIAN'S NAME (Type) SUMIO UEMATSU				23D. ADDRESS Neurosurgery Johns Hopkins Hospital Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/65		24C. NAME OF CEMETERY or CREMATORIUM Holy Trinity Russian Orthodox	
24D. LOCATION (City, town, or county) Elbridge, Md.		24E. DATE REC'D BY HEALTH DEPT. MAR 19 1965		24F. NAME OF REGISTRAR Charles E. Stevens	
24G. FUNERAL DIRECTOR Charles E. Stevens		24H. ADDRESS Charles E. Stevens Funeral Home, Inc. 2501 E. Fort Ave.			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2949		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2949	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Tubman, Olivia</i>		2. DATE AND HOUR OF DEATH <i>3-18-65 3:20 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1600 VINCENT CT</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>UNIVERSITY HOSPITAL</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Maryland 15-01</i>			
		D. STREET ADDRESS (If rural, give location) <i>Baltimore</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>7-25-01</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Harris</i>		14. MOTHER'S MAIDEN NAME <i>Coyton</i>	
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>HOSPITAL CHART</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>420.1 I</i>		CAUSE OF DEATH (A) <i>PROBABLE MYOCARDIAL INFARCT</i> DUE TO (B) <i>HYPERTENSION</i> DUE TO (C) <i>ATHEROSCLOSIS, GENERALIZED</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>3/18/65</i> 19 to <i>3/18/65</i> 19 that (I) <i>(we)</i> last saw the deceased alive on <i>3/18/65</i> 19 and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We, did)</i> (did not) view the body after death.					
23A. SIGNATURE <i>L. Bradley Baker, M.D.</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/18/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>L. BRADLEY BAKER</i>		23D. ADDRESS <i>UNIVERSITY HOSPITAL</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-23-65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Beth. Neth. Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 19 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Baker</i>		25C. FUNERAL DIRECTOR <i>Robert E. Baker</i>	
		ADDRESS <i>1318 N. Calhoun St</i>			

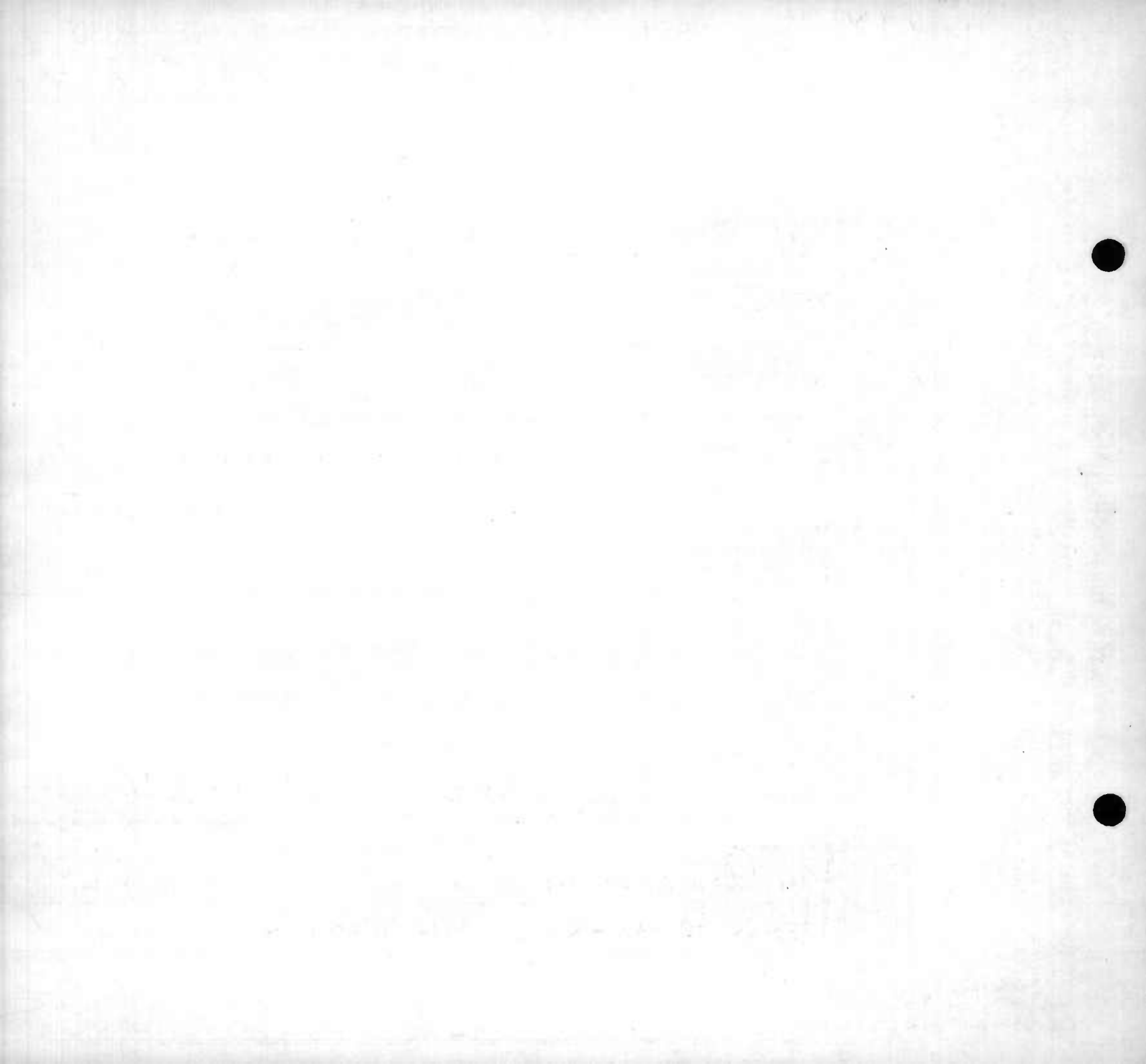




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2950	
BIRTH NO. 65 2950		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Blanche E. Forsyth</i>		2. DATE AND HOUR OF DEATH <i>March 16/65 8 A</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>2911 Kingsley St.</i>		A. STATE <i>Ind</i> B. COUNTY <i>20-06</i>			
5. SEX <i>Female</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	
8. DATE OF BIRTH <i>Apr 14/05</i>		9. AGE (In years, last birthday) <i>59</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Confy Mfg. Co</i>		11. BIRTHPLACE (State or foreign country) <i>Ind</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Joseph Cocnavitch</i>		14. MOTHER'S MAIDEN NAME <i>Hora</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Geo. E. Forsyth, 2911 Kingsley St</i>	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <i>Acute coronary occlusion</i> DUE TO (B) <i>myocardial heart disease</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>November 1964</i> to <i>March 16 1965</i> , that (I) (we) last saw the deceased alive on <i>March 10 1965</i> and that in (my) (our) opinion death occurred on the date <i>3.16.65</i> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Henry Armanas M.D.</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3.19.1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>HENRY ARMANAS M.D.</i>		23D. ADDRESS <i>1934 Wilkens Ave. Balto. 23, Ind.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/19/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>London Plk</i>	
24D. LOCATION <i>Balto. 29, Ind</i>		24E. DATE REC'D BY HEALTH DEPT. <i>MAR 19 1965</i>		24F. NAME OF REGISTRAR <i>Robert E. Forsyth</i>	
24G. FUNERAL DIRECTOR <i>Edmondson</i>		24H. ADDRESS <i>4101 Edmondson</i>			



BIRTH NO. 65 2951 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MINOR Allen JONES

2. DATE AND HOUR PRONOUNCED DEAD

March 17, 1965 7:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore #7

D. STREET ADDRESS (If rural, give location)

1140 St. Agnes Lane

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10/29/13

9. AGE (In years  
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Maintenance Man Congress Inn

10B. KIND OF BUSINESS OR INDUSTRY

Hotel

11. BIRTHPLACE (State or foreign country)

Mississippi

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

W. E. Jones

14. MOTHER'S MAIDEN NAME

Barclia Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

428-05-2269

17. INFORMANT

Mrs. Lucille Jones, 1140 St. Agnes Lane

ADDRESS

Zone 4 Lane

18. E904.01

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Craniocerebral Injuries, fresh.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Fatty Metamorphosis of Liver.

19A. DATE OF OPERATION

3/17/65

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1140 St. Agnes Lane

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
3 17 '65

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Apparent fall.

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
3/17/6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

3/19/65

23C. NAME OF CEMETERY or CREMATORY

Laurel

23D. LOCATION

Laurel, Mississippi

24A. DATE REC'D BY HEALTH DEPT.

MAR 19 1965

24B. NAME OF REGISTRAR

Gibert E. Fairley

24C. FUNERAL DIRECTOR

Wibbey N. 4101 Edmondson

ADDRESS

VALERIE BOHIG

ANALYST

W. H. H. H.

W. H. H. H.

W. H. H. H.

BIRTH NO. 65 2952 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2952

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LUKE C. ROSS

2. DATE AND HOUR PRONOUNCED DEAD

March 16, 1965

3:00 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Found in submerged automobile  
at foot of Fells Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

419 East 22nd Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

7-14-1914

9. AGE (In years  
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.  
Months; Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

M.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Luke Ross

14. MOTHER'S MAIDEN NAME

Bell Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Ester Ross 419 E 22nd St

18.

E823.8

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Undetermined at autopsy (far  
DUE TO advanced postmortem decomposition)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Presumed drowning  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Harbor

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Harbor foot of Fells Street

21D. TIME  
OF INJURY  
(APPROX.)

Unknown

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Car went off pier at end of Fells Street

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-17-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3-19-65

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cem. A. A. Co

23D. LOCATION

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

MAR 19 1965

24B. NAME OF REGISTRAR

G. E. Jenkins

24C. FUNERAL DIRECTOR

Raymond Sanders 217 E Preston St

ADDRESS





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2953		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2953	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) ROBERT PRIDE			3-16-65 1:50 P.M. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND B. COUNTY 8-07		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 13		
			D. STREET ADDRESS (If rural, give location) 1715 E. PRESTON STREET		
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-21-14	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME FRANK PRIDE		14. MOTHER'S MAIDEN NAME NELLIE JONES		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record	
18. 493X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Pneumonia (B) DUE TO (C) Alcololism		INTERVAL BETWEEN ONSET AND DEATH 3 days	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <del>Yes</del> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 3/16/65 9:30 P. to 3/16/65 1:50 P. that (X) (we) lost saw the deceased alive on 3/16/65 1:50 P. 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Virgil Brown			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/16/65
23C. PHYSICIAN'S NAME (Type) VIRGIL BROWN			23D. ADDRESS JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Shipped		24B. DATE 3-19-65		24C. NAME OF CEMETERY or CREMATORY Bethel	
24D. LOCATION Mehering Virginia		24E. DATE RECEIVED BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. DATE RECEIVED BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR Rogger Sander	
24J. ADDRESS		24K. ADDRESS		24L. ADDRESS	

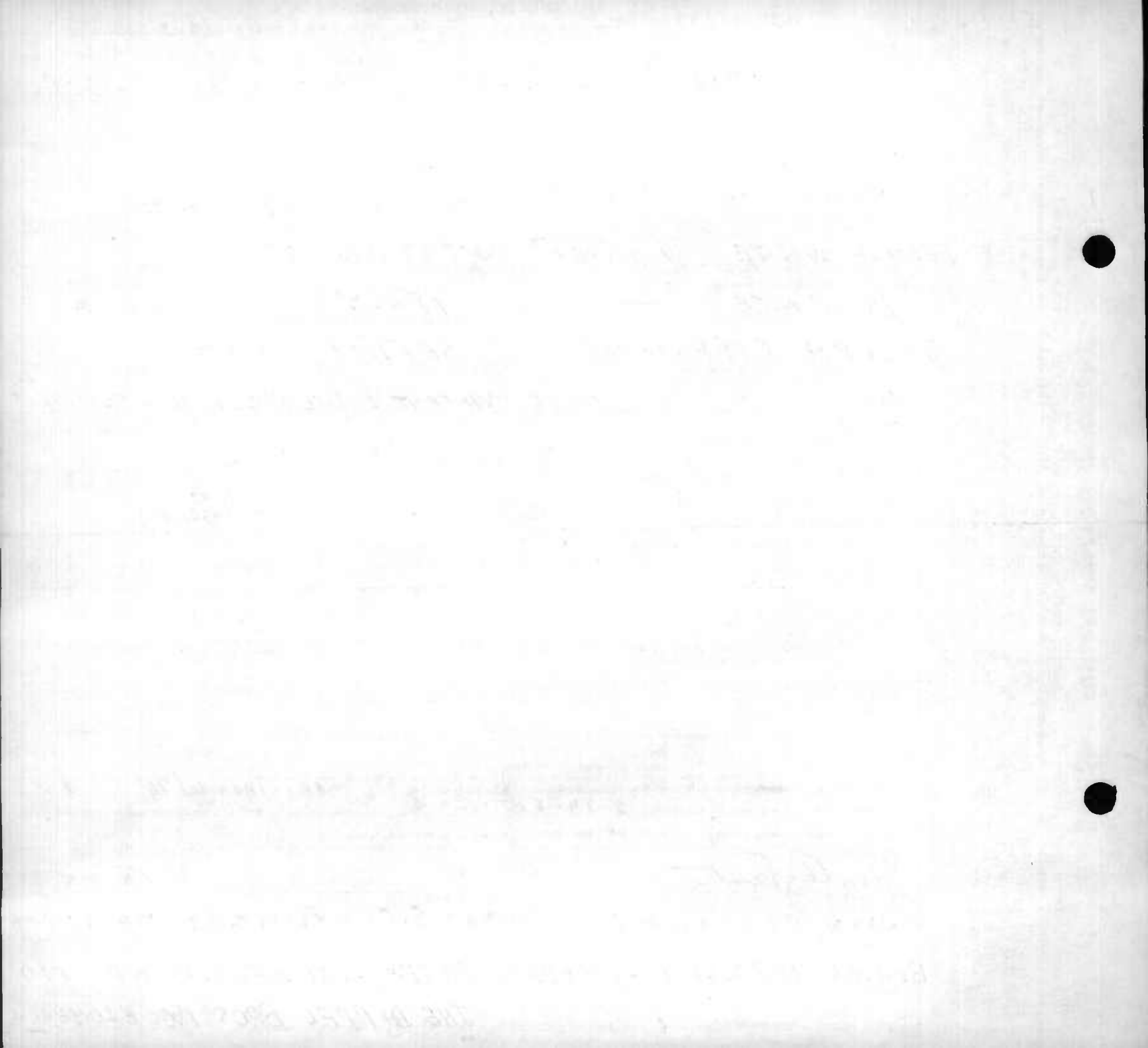




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

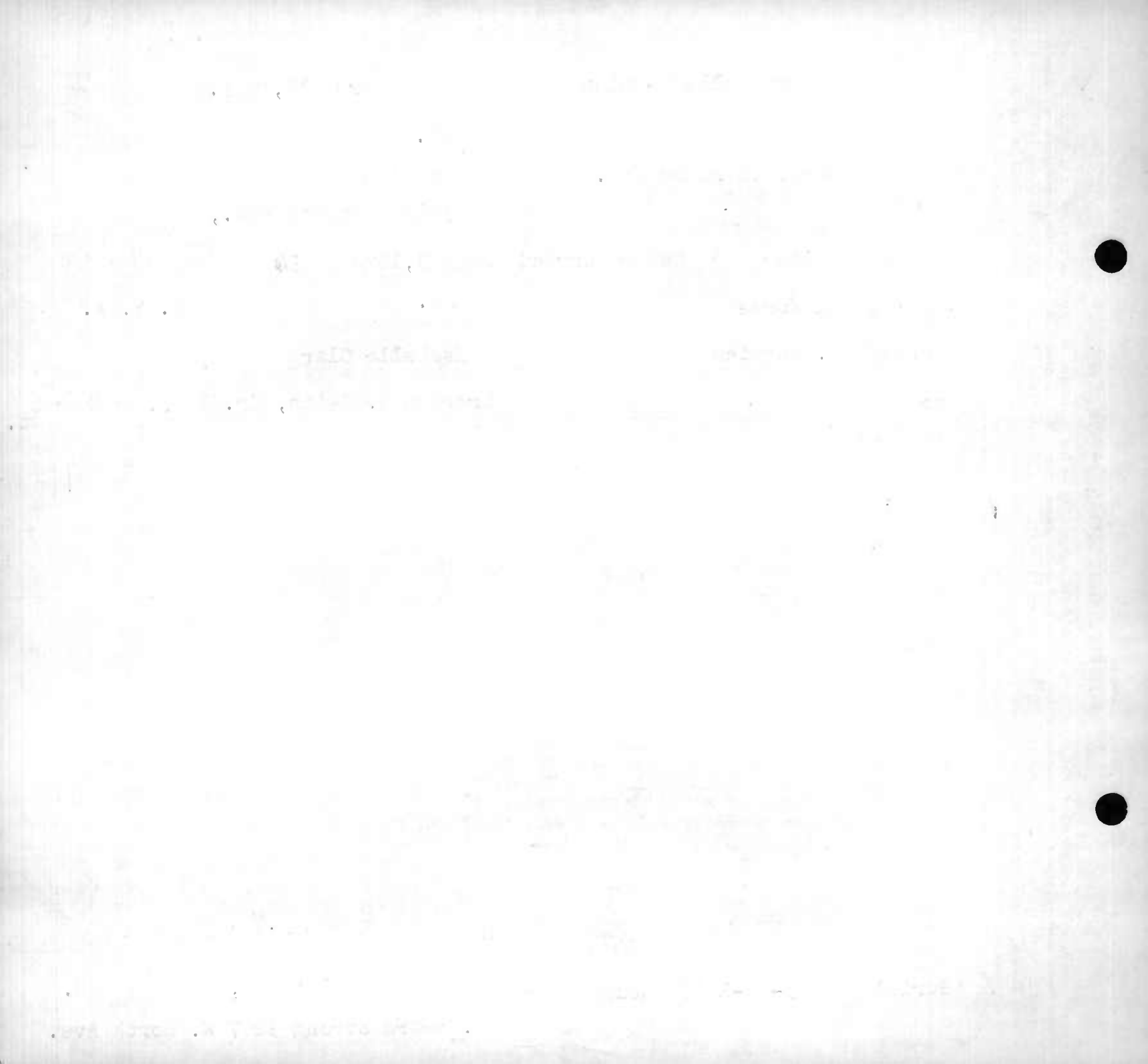
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 2954		CERTIFICATE OF DEATH		65 2954	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
ALBINA DEL PIZZO			MARCH 16 1965 5:00P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
MERCY HOSPITAL			MARYLAND 3-02		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE		
			D. STREET ADDRESS (If rural, give location)		
			1006 EASTERN AVE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
FEMALE	WHITE	WIDOWED	OCT 27-1882	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSE WIFE		—		ITALY	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOSEPH CIPPRIANO		SEFINA UNK.		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		NONE		VINCENT L. DEL PIZZO 1006 EASTERN AVE	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
CORONARY THROMBOSIS					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
ARTERIO-SCLEROTIC HEART DISEASE					
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the <del>hospital</del> ) attended the deceased from January 1, 1960 to March 16, 1965, that (I) (we) lost saw the deceased alive on 2-17-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (He) (She) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John Costantini				3-18-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOHN COSTANTINI		234 S. CONKLING ST. BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		MAR 20 65		HOLY REDEEMER CEM	
				24D. LOCATION (City, town, or county) (State)	
				4430 BELAIR RD MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 19 1965		John E. ...		THE DAPPEL BROS 1800 E LOMBARD ST	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 2955		Registered No. 65 2955	
BIRTH NO. 65 2955				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				Cora Beale Martien		March 17, 1965. 104. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
Ashburton House Inc.				Md.		15-06	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				3213 Westwood Ave.,			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Female		White		Never Married		July 3, 1870	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthdate)		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
Practical Nurse				94		3 17 10 A.M.	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Md.				U. S. A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph C. Martien				Isabelle Clark			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				none		Creston M. Smith, Sr. 518 N. Lyndhurst St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
491X I				B bronchopneumonia		2 days	
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II				Arteriosclerosis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Sept. 11, 1963 to March 17, 1965, that (I) (we) last saw the deceased alive on March 10, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Isidore I. Levy						3-18-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Isidore I. Levy				M.D. 2322 Canton Place Balto. 17 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3-20-1965		Loudon Park		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 19 1965		G. Howard Strong		3207 W. North Ave.			



T-250

65 2956

BALTIMORE CITY HEALTH DEPARTMENT

65 2956

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES TYSON

2. DATE AND HOUR PRONOUNCED DEAD

March 15, 1965

9:27 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1329 N. Fremont Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1329 N. Fremont Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

10-9-1904

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Kitchen Helper

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

T

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WWI

16. SOCIAL  
SECURITY NO.

216-01-388

17. INFORMANT

ADDRESS

Mabel Knight - 947 Bethune Rd

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular  
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m. WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-16-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3-19-65

23C. NAME of CEMETERY or CREMATORY

Balto. National

23D. LOCATION

(City, town, or county)

Baltimore

(State)

md

24A. DATE REC'D BY HEALTH DEPT.

MAR 19 1965

24B. NAME OF REGISTRAR

G. E. Taylor

24C. FUNERAL DIRECTOR

Dunnell &amp; Oden - Balto. md.

ADDRESS

10-1-1904

10-1-1904

10-1-1904

Kitchen

Walt

10-1-1904

John Adams

March 3-1912

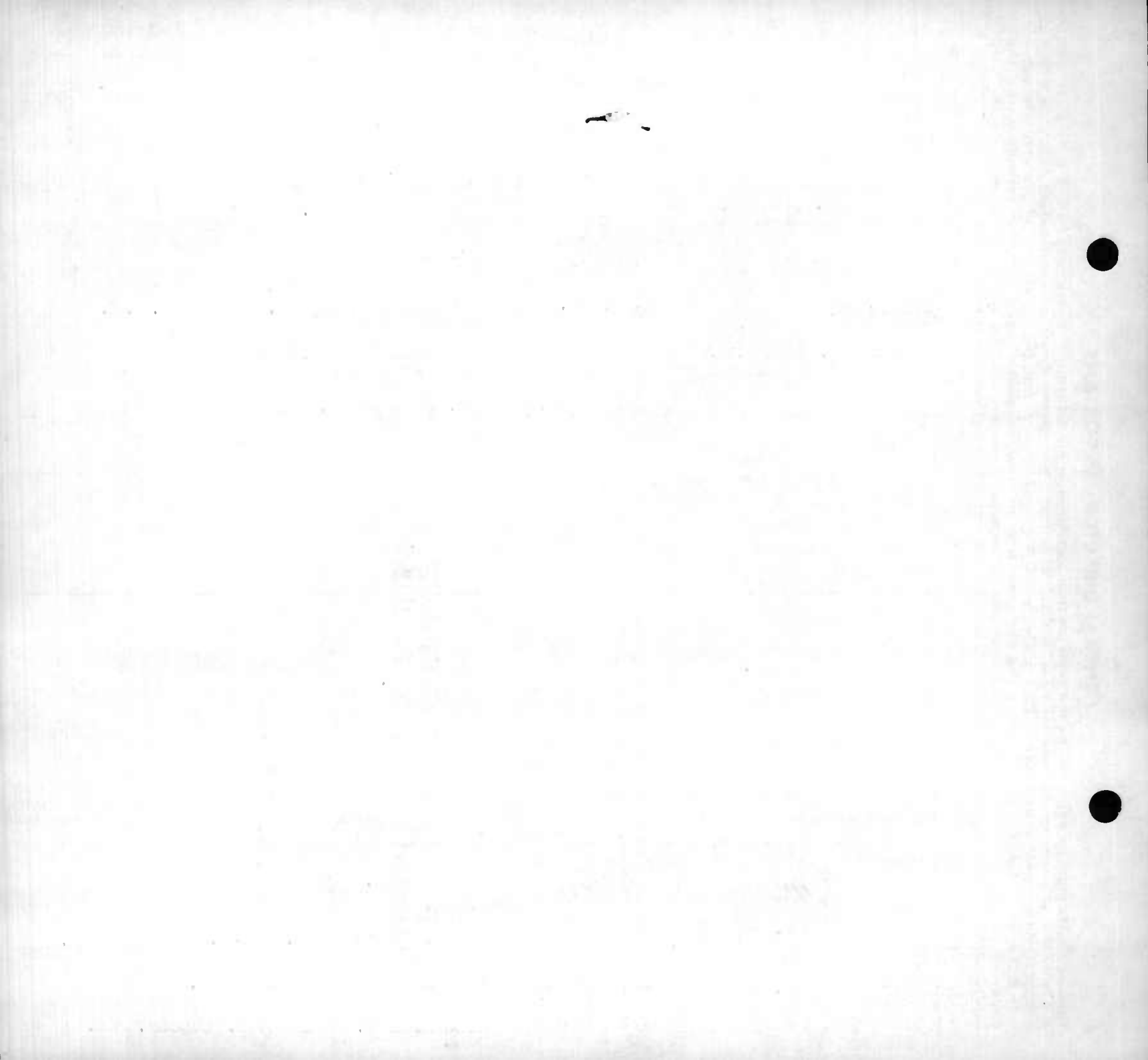
James O. Adams



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

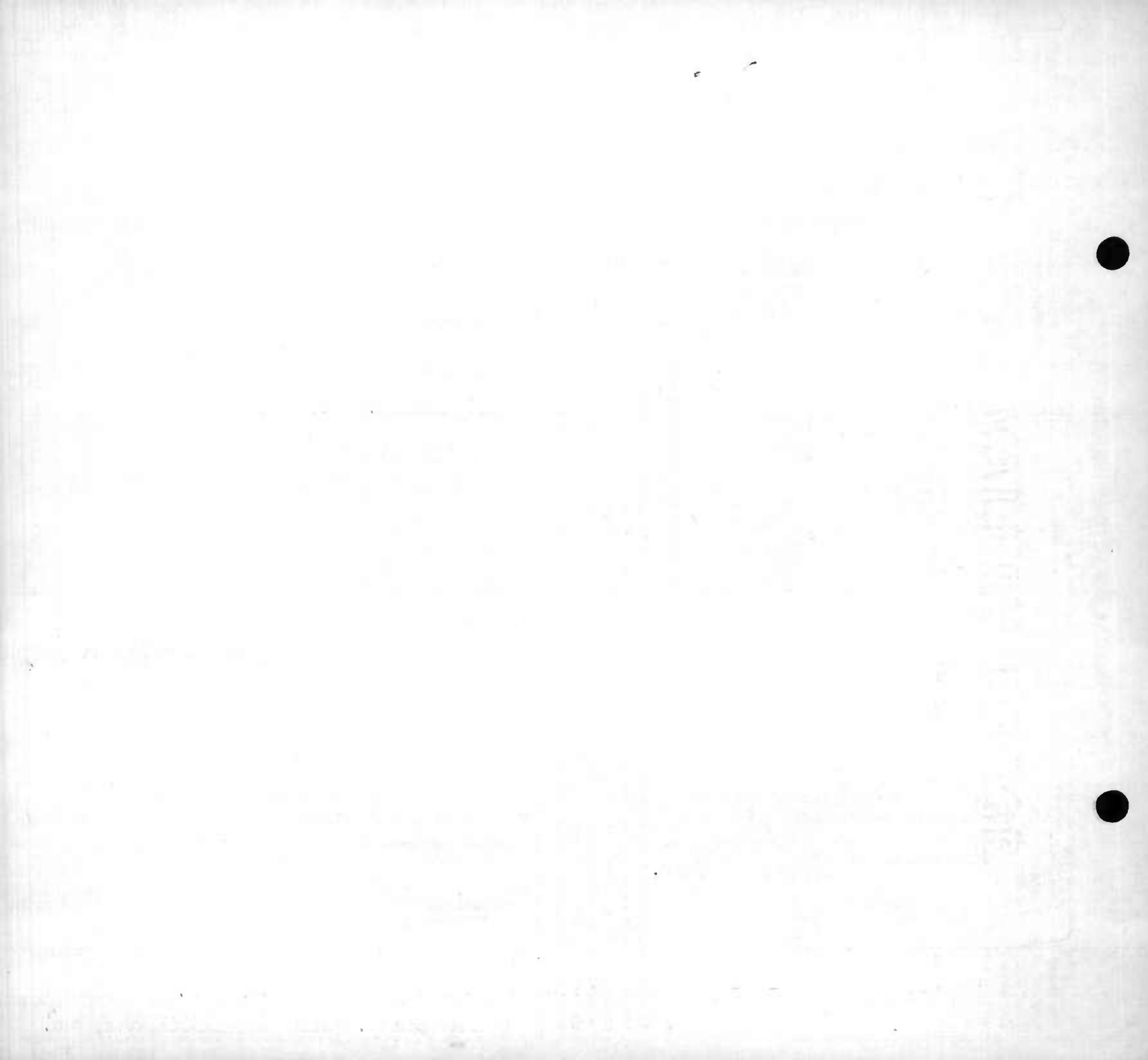
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2957		CERTIFICATE OF DEATH		Registered No. 65 2957	
1. NAME OF DECEASED (Type or Print) <b>Dotterer, Mahlon Albert</b>				2. DATE AND HOUR OF DEATH <b>March 17 1965</b>				7.30P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Joseph Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #36</b>		D. STREET ADDRESS (If rural, give location) <b>8219 Belair Rd.</b>	
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>12-16-02</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Penna. R. Rd.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Nelson C. Dotterer</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Whitmore</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>216035114</b>		17. INFORMANT <b>Mr. Nelson W. Dotterer</b>		ADDRESS <b>Same</b>		
18. <b>327.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Emphysema with Pneumonitis</b> DUE TO (B) _____ DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>March 10 19 65</b> to <b>March 17 19 65</b> , that (I) (we) last saw the deceased alive on <b>March 17 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Jimmy P. Cordero</b>						23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>Jimmy P. Cordero</b>						23D. ADDRESS <b>1400 N. Caroline St. Balto. 21213 Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/20/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 19 1965</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., Balto., Md.</b>			ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

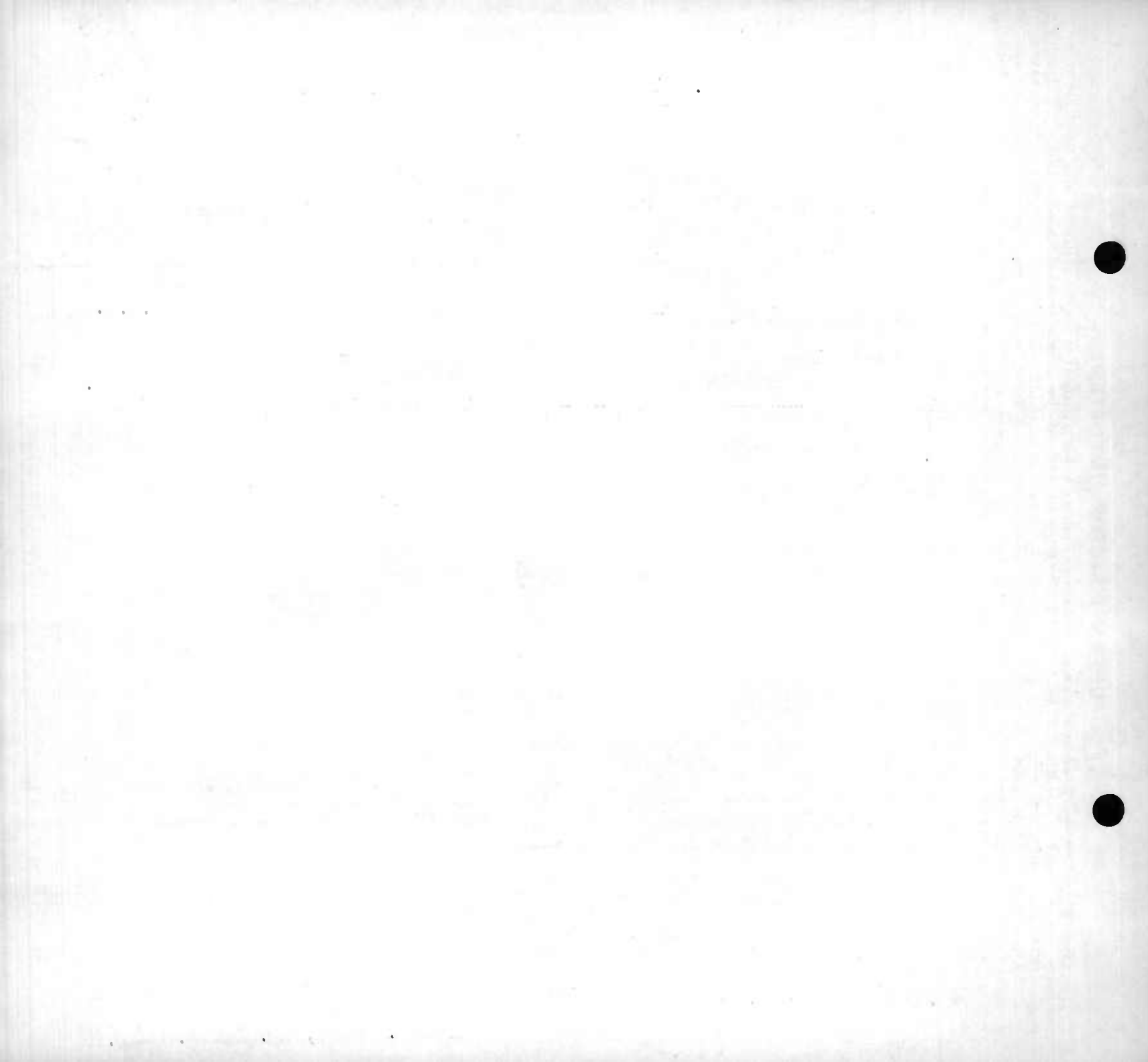
BIRTH NO. 65 2958		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2958	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Jerome F. Carroll, SR.</i>			2. DATE AND HOUR OF DEATH <i>3/16/65 10:00 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secour Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>2703</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>5103 ARABIA AVE.</i>		
5. SEX <i>male</i>	6. RACE <i>white</i>	7. <del>MARRIED</del> NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>3/11/05</i>	9. AGE (In years last birthday) <i>60yr</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>POLICE, DEPT.</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto, Maryland</i>	
13. FATHER'S NAME <i>Josiah J. Carroll</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Lillian W. Carroll</i>
18. <i>153.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>carcino ma of Transverse colon with multiple metastasis</i> (B) <i>carcino ma of transverse colon</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>10 months</i> <i>4 years</i>
19A. DATE OF OPERATION <i>5-15-64</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>right Hemicolectomy</i>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-14, 1965</i> to <i>3-16, 1965</i> , that (I) (we) last saw the deceased alive on <i>3-16, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Vichitr Duapondh</i> M.D.			23B. DATE SIGNED <i>3-16-65</i>		
23C. PHYSICIAN'S NAME (Type) <i>VICHITR DUAPONDH</i> M.D.			23D. ADDRESS <i>BON SECOUR Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>3-20-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 19 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. [unclear]</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i>	
				ADDRESS <i>Baltimore, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2959		CERTIFICATE OF DEATH		Registered No. 65 2959	
1. NAME OF DECEASED (Type or Print) <i>Mary R. Siney</i>				2. DATE AND HOUR OF DEATH <i>3/17/65</i> <i>10:00 P. M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>3023 Chesterfield Avenue</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>26-03</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3023 Chesterfield Avenue</i>					
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>1/24/81</i>	9. AGE (In years last birthday) <i>84</i>	(If Under 1 Yr. Months: Days) (If Under 24 Hrs. Hours: Min.)				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress (retired)</i>			10B. KIND OF BUSINESS OR INDUSTRY -----			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Siney</i>			14. MOTHER'S MAIDEN NAME <i>Mary Whalen</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>215-09-7728</i>		17. INFORMANT <i>Miss Anna Siney 3023 Chesterfield Ave.</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>331X1</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>Cerebral Hemorrhage - R. Hemisphere</i> DUE TO (B) <i>Generalized Arteriosclerosis</i> DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>Several years</i>			
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>1962</i> to <i>March 17 1965</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>March 17 1965</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <i>Loy M. Zimmerman</i> M.D.						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3/18/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Loy M. Zimmerman</i>						23D. ADDRESS <i>3202 Harford Rd. Baltimore Md.</i>			
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>3/22/65</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 19 1965</i>			25B. NAME OF REGISTRAR <i>Walter E. Sals...</i>			25C. FUNERAL DIRECTOR ADDRESS <i>John A. Moran, Inc. 3000 E. Balto. St.</i>			

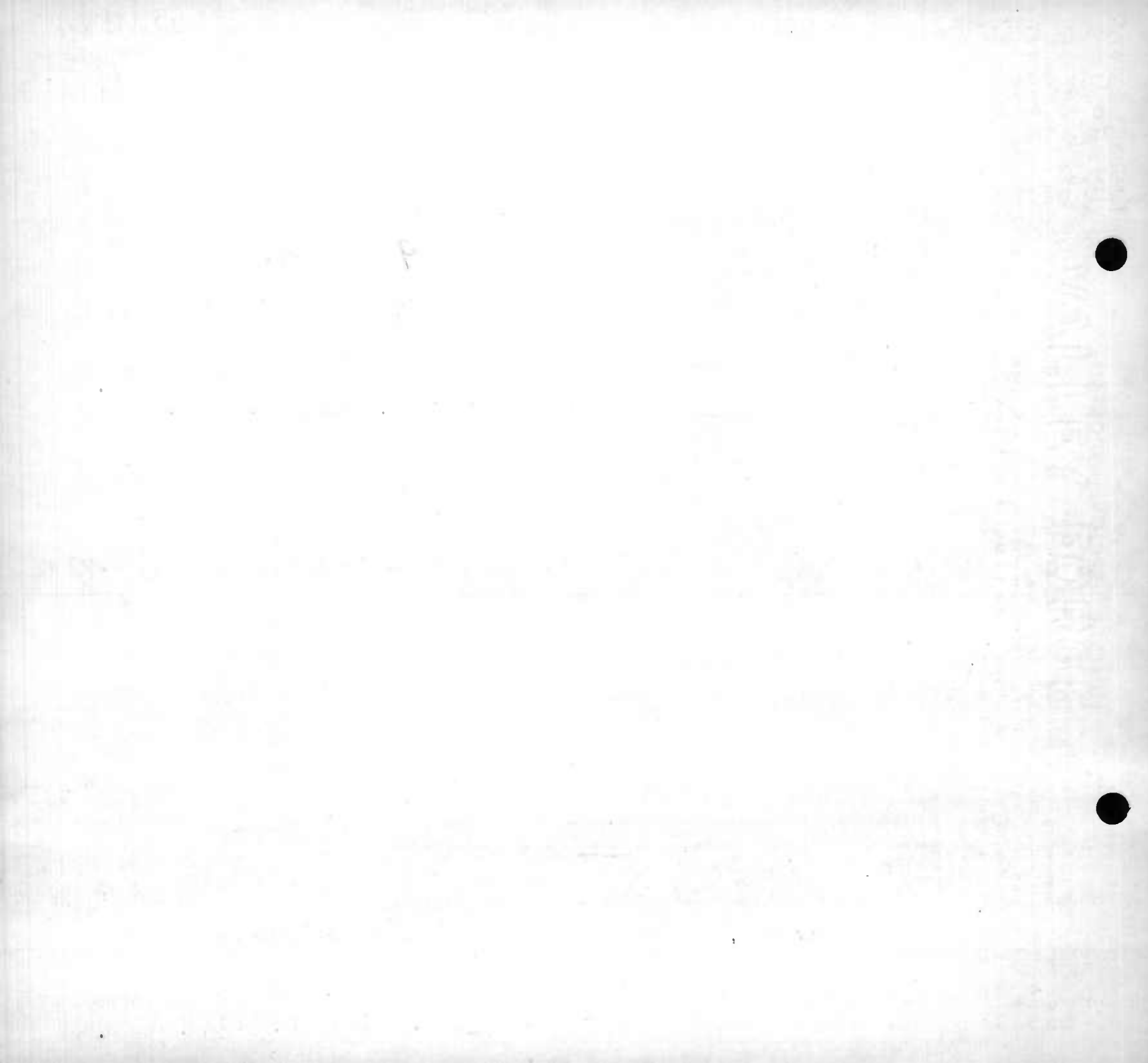


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Baltimore City Health Department	
BIRTH NO. 65 2960				Registered No. 65 2960	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Rosina Burns</u>			2. DATE AND HOUR OF DEATH <u>3/16/65</u> <u>9:55</u> P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>26-10</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>244 S. East Ave.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>1/24/1944</u>	9. AGE (In years last birthday) <u>21</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
13. FATHER'S NAME <u>Joseph Franz</u>			14. MOTHER'S MAIDEN NAME <u>Frances Kimble</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William H. Burns, Sr.</u> ADDRESS <u>244 S. East Ave.</u>	
18. <u>420.11</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Cardiovascular disease.</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>25 years</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7pm March 16, 1965</u> to <u>8pm March 16, 1965</u> , that (I) (we) last saw the deceased alive on <u>March 16, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Hubert J. Harwick</u> M.D.			23B. DATE SIGNED <u>March 16, 1965</u>		
23C. PHYSICIAN'S NAME (Type) <u>Hubert J. Harwick</u>			23D. ADDRESS <u>Johns Hopkins Hosp.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/20/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. STATE <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 19 1965</u>		25B. NAME OF REGISTRAR <u>John A. Moran</u>		25C. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u>	
25D. ADDRESS <u>3000 E. Balto. St</u>					

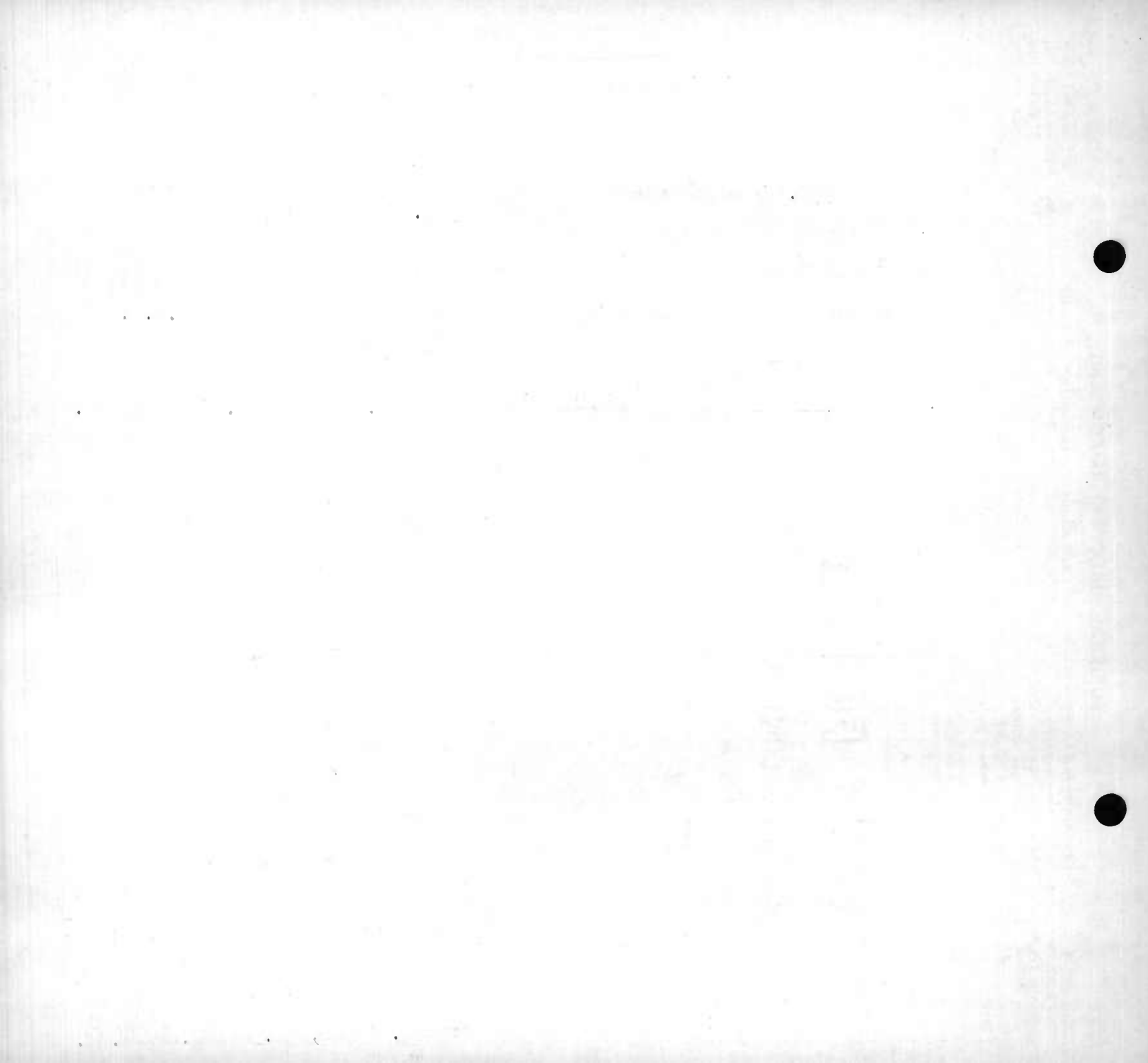




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 2961</span>	
BIRTH NO. <span style="float: right;">65 2961</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Harry William Hammen</i>		2. DATE AND HOUR OF DEATH <i>3/18/65 12 15 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>13 N. Highland Avenue</i>			A. STATE <i>Maryland</i> B. COUNTY <i>26-44</i>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>13 N. Highland Avenue</i>		
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>8/28/14</i>	9. AGE (In years last birthday) <i>50</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Trucking</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Harry Hammen</i>		14. MOTHER'S MAIDEN NAME <i>Alice Glass</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>215-10-6493</i>		17. INFORMANT <i>Margaret M. Hammen</i>	
				ADDRESS <i>13 N. Highland Ave.</i>	
18. <i>502.01</i>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO <i>chronic Bronchitis</i>		<i>?</i>
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<i>Decubal ulcer</i>		<i>3 years</i>
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>the physician</del> ) attended the deceased from <i>9/10 1964</i> to <i>3/18 1965</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>3/18 1965</i> and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Louis J. Klimes</i>				23B. DATE SIGNED <i>3/19/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>L.F. KLIMES M.D.</i>				23D. ADDRESS <i>2623 E. MONUMENT ST BALTO 5 MD.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/22/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 19 1965</i>		25B. NAME OF REGISTRAR <i>John A. Moran, Inc.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>3000 E. Balto. St.</i>	



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		65 2962	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD	
JENNIE V. HARRIS				March 18, 1965 11:03 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
St. Joseph's Hospital				Maryland	
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
				Baltimore	
				D. STREET ADDRESS (If rural, give location)	
				1129 N. Caroline Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	Negro	Widowed	January 13, 1885	80	
11. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Maryland				James F. Ruby	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
Baltimore		Ida Ruby		No	
D. STREET ADDRESS (If rural, give location)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
1129 N. Caroline Street				Ida Ruby	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
Arteriosclerotic Cardiovascular Disease.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial		March 19, 1965		Baldwin Natl Cem.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
MAR 19 1965		Robert C. [illegible]		Frank E. [illegible]	
				ADDRESS	
				1129 N. Caroline St	

# VALLEY FORGE

PAID TO ORDER

Pay to the order of  
The Treasurer  
of the Valley Forge  
Institution  
Five hundred and no/100  
Dollars

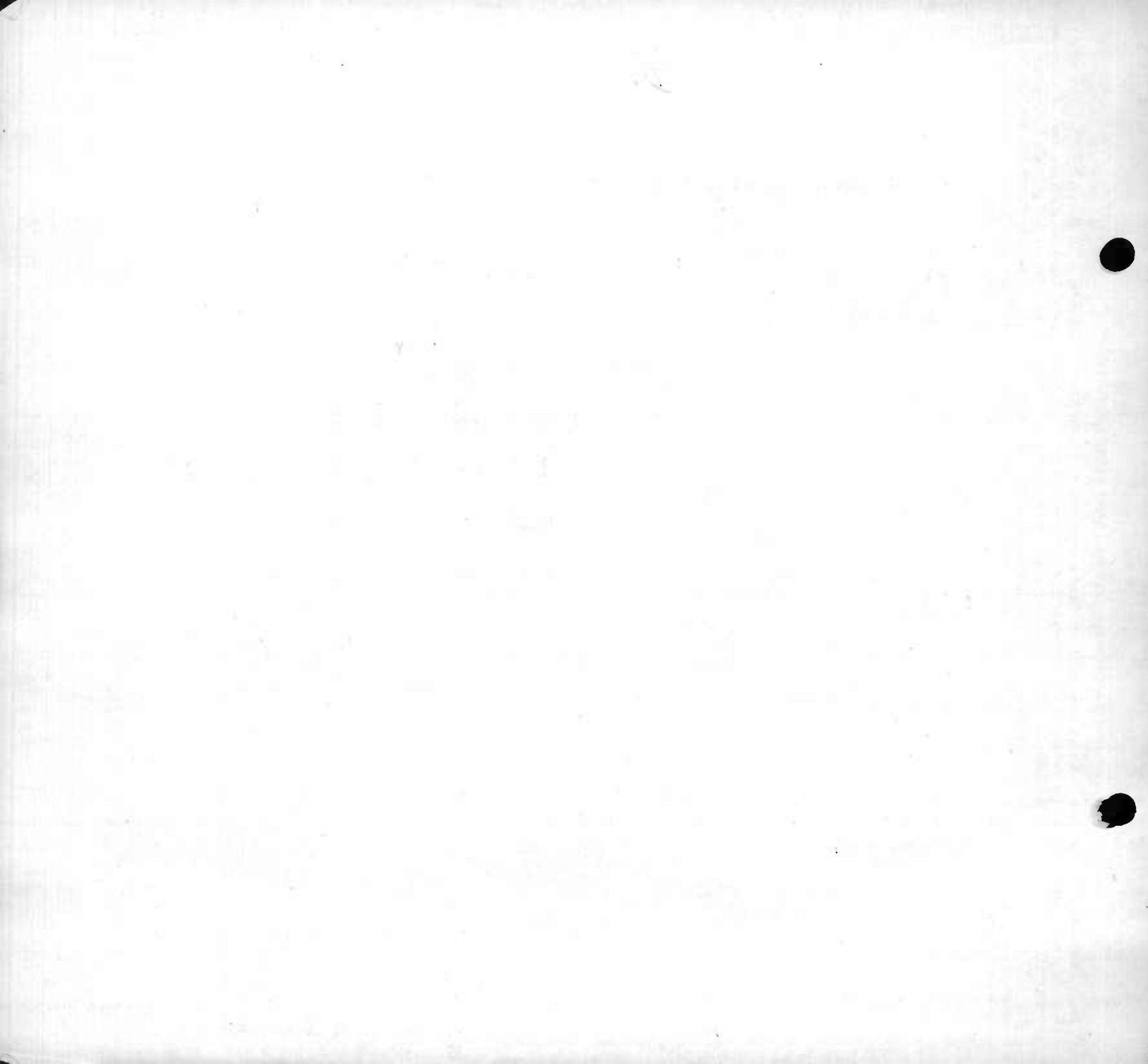
Clear

Five hundred and no/100  
Dollars

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 2963</span>	
BIRTH NO. <span style="float: right;">65 2963</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="float: right;">RAY, Mary D.</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">3/17/65 13 15 P M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="float: right;">MARYLAND</span> B. COUNTY <span style="float: right;">X</span>			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">(If not in hospital or institution, give street address or location)</span> <span style="float: right;">THE JOHNS HOPKINS HOSPITAL</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="float: right;">BALTIMORE</span> D. STREET ADDRESS (If rural, give location) <span style="float: right;">904 STODDARD COURT</span>			
5. SEX <span style="float: right;">FEMALE</span>	6. RACE <span style="float: right;">COLORED</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="float: right;">WIDOW</span>	8. DATE OF BIRTH <span style="float: right;">1-2-95</span>	9. AGE (In years last birthday) <span style="float: right;">70</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="float: right;">Piedmont N. Carolina</span>	
13. FATHER'S NAME <span style="float: right;">MALCOLM BROWN</span>		14. MOTHER'S MAIDEN NAME <span style="float: right;">MARY Brown</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <span style="float: right;">no</span>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="float: right;">George McLaughlin 1328 Melrose Ave</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="float: right;">I 170 X I</span>		CAUSE OF DEATH (A) <span style="float: right;">Pneumonia + atelectasis</span> DUE TO (B) <span style="float: right;">Metastatic CA @ breast</span> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <span style="float: right;">1 week</span> <span style="float: right;">4 years</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="float: right;">YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">3/12</span> 1965 to <span style="float: right;">3/17</span> 1965, that (I) (we) lost saw the deceased alive on <span style="float: right;">3/17</span> 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="float: right;">Gino V. Segre</span>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="float: right;">3/17/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">GINO V. SEGRE</span>		23D. ADDRESS <span style="float: right;">JOHNS HOPKINS HOSP.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <span style="float: right;">Removal March 20/65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Fayetteville N.C.</span>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">MAR 19 1965</span>		25B. NAME OF REGISTRAR <span style="float: right;">Robert E. Fairbank</span>	
25C. FUNERAL DIRECTOR <span style="float: right;">Milton E. Elchman</span>		ADDRESS <span style="float: right;">1129 N. Carroll St</span>			

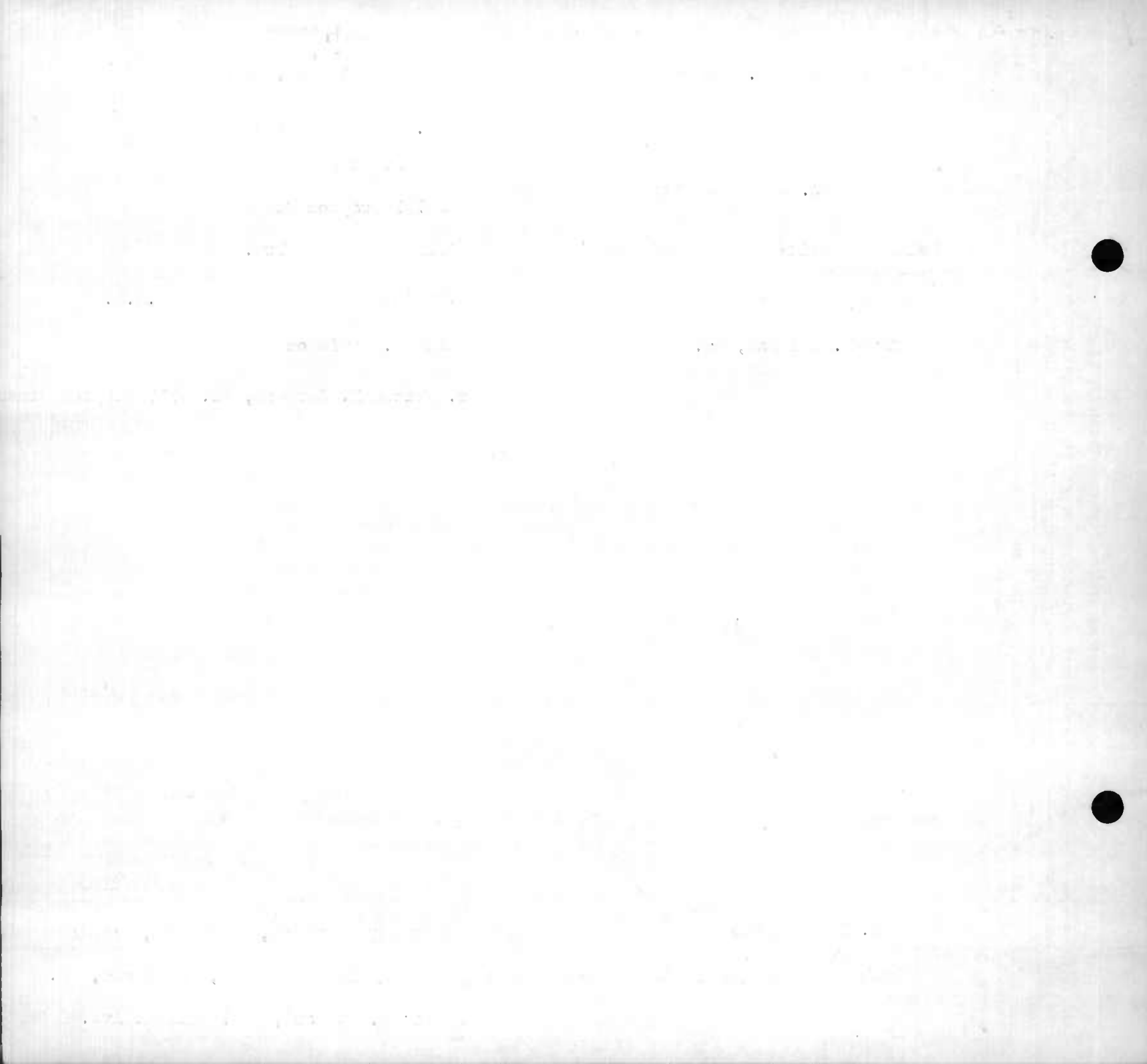




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 2964					CERTIFICATE OF DEATH					Registered No. 65 2964				
1. NAME OF DECEASED (Type or Print) Donald E. Bergman					2. DATE AND HOUR OF DEATH March 17, 1965 6:00 p.m.					M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Arbutus 5300 D. STREET ADDRESS (If rural, give location) 4777 Drayton Green									
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 6/4/1940		9. AGE (In years last birthday) 24 Yrs.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed					10B. KIND OF BUSINESS OR INDUSTRY									
13. FATHER'S NAME Merton M. Bergman, Sr.					14. MOTHER'S MAIDEN NAME Edith E. Davidson									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS 21227 Mr. Merton M. Bergman, Sr. 4777 Drayton Green				
18. 754,71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) arterial-venous fistula of the cerebral vessels (B) DUE TO (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										INTERVAL BETWEEN ONSET AND DEATH congenital				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1-30-1963 to 2/20-1965, that (I) (we) last saw the deceased alive on 2/20-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Dr. Yu Chen Lee M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>										23B. DATE SIGNED 3/18/1965				
23C. PHYSICIAN'S NAME (Type) Dr. Yu Chen Lee					23D. ADDRESS M.D. University Hospital, Baltimore, Maryland									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 3/20/1965					24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery				
										24D. LOCATION (City, town, or county) (State) Wilkens Avenue, Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. MAR 19 1965					25B. NAME OF REGISTRAR Gilbert E. Stachura					25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. # 29				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

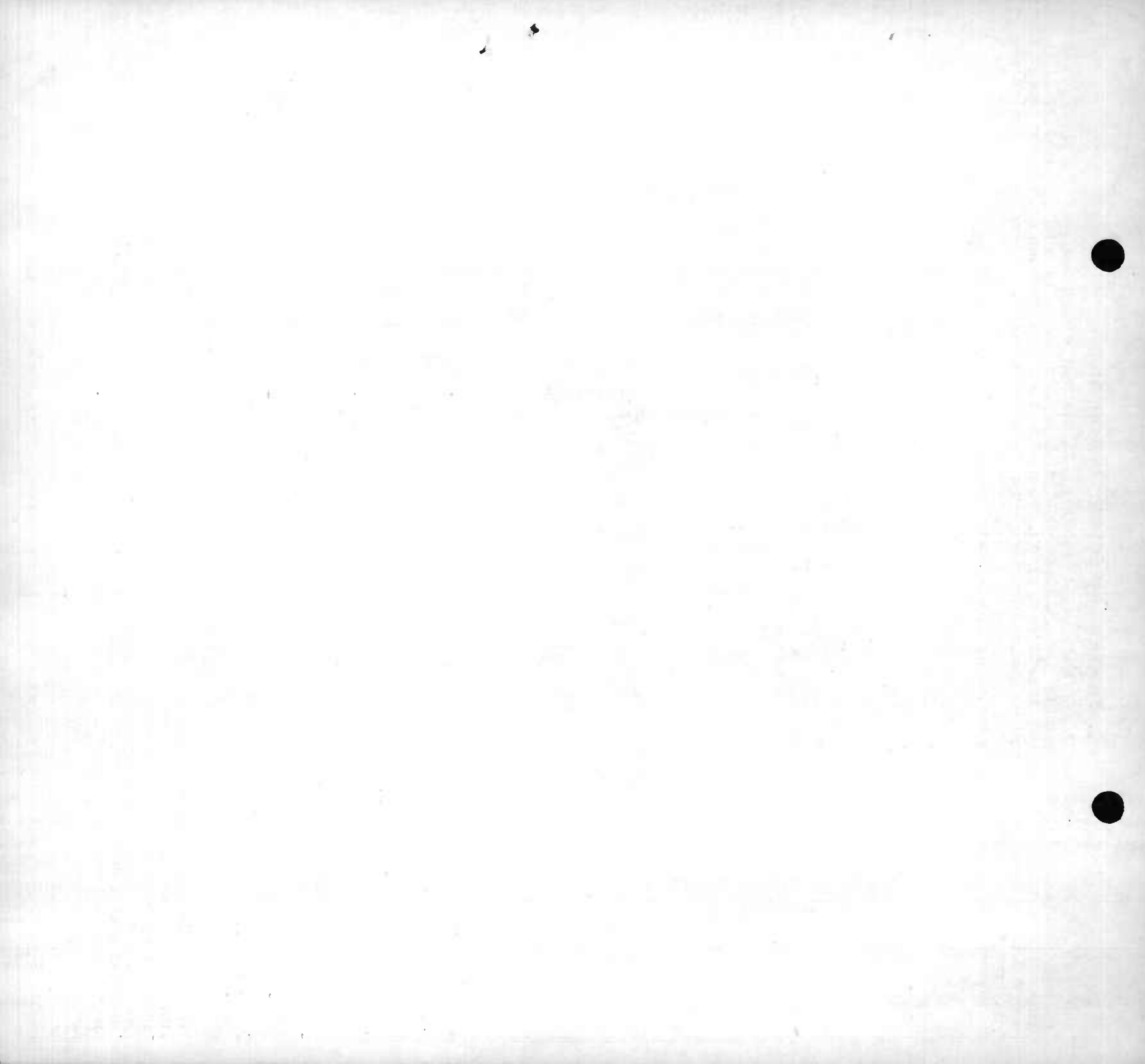
BIRTH NO. 65 2965				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2965	
1. NAME OF DECEASED (Type or Print) <u>Johnson, Joseph Paul</u>				2. DATE AND HOUR OF DEATH <u>March 18 1965</u> <u>11:40 P.</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>University Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>XXXXXXXXXX</u> <u>Md.</u> B. COUNTY <u>21-02</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>XXXXXXXXXXXX</u> <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>1316 S. Carey Street</u>			
5. SEX <u>M</u>	6. RACE <u>W.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>1/12/03</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Tailor</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ed Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Oden</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Edward P. Johnson-402 Tydings Ave</u>		ADDRESS <u>Marley Park, Glen Burnie, Md.</u>	
18. <u>502.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Bronchial Obstruction</u> DUE TO (B) <u>Chronic Bronchitis; Emphysema</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>16 Mar 65</u> 19 to <u>18 Mar 65</u> 19 that (I) (we) last saw the deceased alive on <u>18 Mar 65</u> 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John W. Eckholdt</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>18 Mar 65</u>	
23C. PHYSICIAN'S NAME (Type) <u>John W. Eckholdt</u>				23D. ADDRESS <u>University Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-22-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 19 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Harley</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard-4107 Wilkens Ave-21229</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 2966		CERTIFICATE OF DEATH		65 2966	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Emory Robert Watson		3-18-65 11 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY 9-01	
The Hospital For the Women of Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		3812 Kimble Rd.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
male	white	married	2-24-08	57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
mechanic		Floyd Smith Co.		Balt-Md.	
13. FATHER'S NAME Robert		14. MOTHER'S MAIDEN NAME HELEN BRUCE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215101044		17. INFORMANT MRS. PEARL W. WATSON, 3812 KIMBLE RD. Patient's chart.	
unknown					
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Massive myocardial			
ANTECEDENT CAUSES		(B) DUE TO Infarction			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-18-65 to 3-18-65, that (I) (we) last saw the deceased alive on 3-18-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gordon J. Toppas		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-18-65	
23C. PHYSICIAN'S NAME (Type) ANBECITA TOPPAS		23D. ADDRESS M.D. Woman's Hosp. Bldg. 17 W. 17th St.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/22/65		24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 19 1965		25B. NAME OF REGISTRAR Gordon J. Toppas		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 2967		CERTIFICATE OF DEATH				Registered No. 65 2967			
1. NAME OF DECEASED (Type or Print) Anna Hock					2. DATE AND HOUR OF DEATH March 18, 1965				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1717 Lydonlea Way					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1717 Lydonlea Way				
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH May 30, 1887	9. AGE (In years last birthday) 83	10. CITIZEN OF WHAT COUNTRY? USA		11. BIRTHPLACE (State or foreign country) Maryland		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Zieler					14. MOTHER'S MAIDEN NAME Catherine Schlauffer				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Charles M. Hock		ADDRESS same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) ARTERIOSCLEROTIC HEART DUE TO DISEASE (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH INDEF. 5 years				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12/23/63 to 18 MAR 1965, that (I) (we) lost saw the deceased alive on 18 MAR 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE John B. DeHoff					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 19 March 65		
23C. PHYSICIAN'S NAME (Type) John B. DeHoff					23D. ADDRESS M.D. 1701 Meridene Drive - Balto. 12, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 3-22-65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 19 1965		25B. NAME OF REGISTRAR G. E. Tolson		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS Baltimore, Md.			





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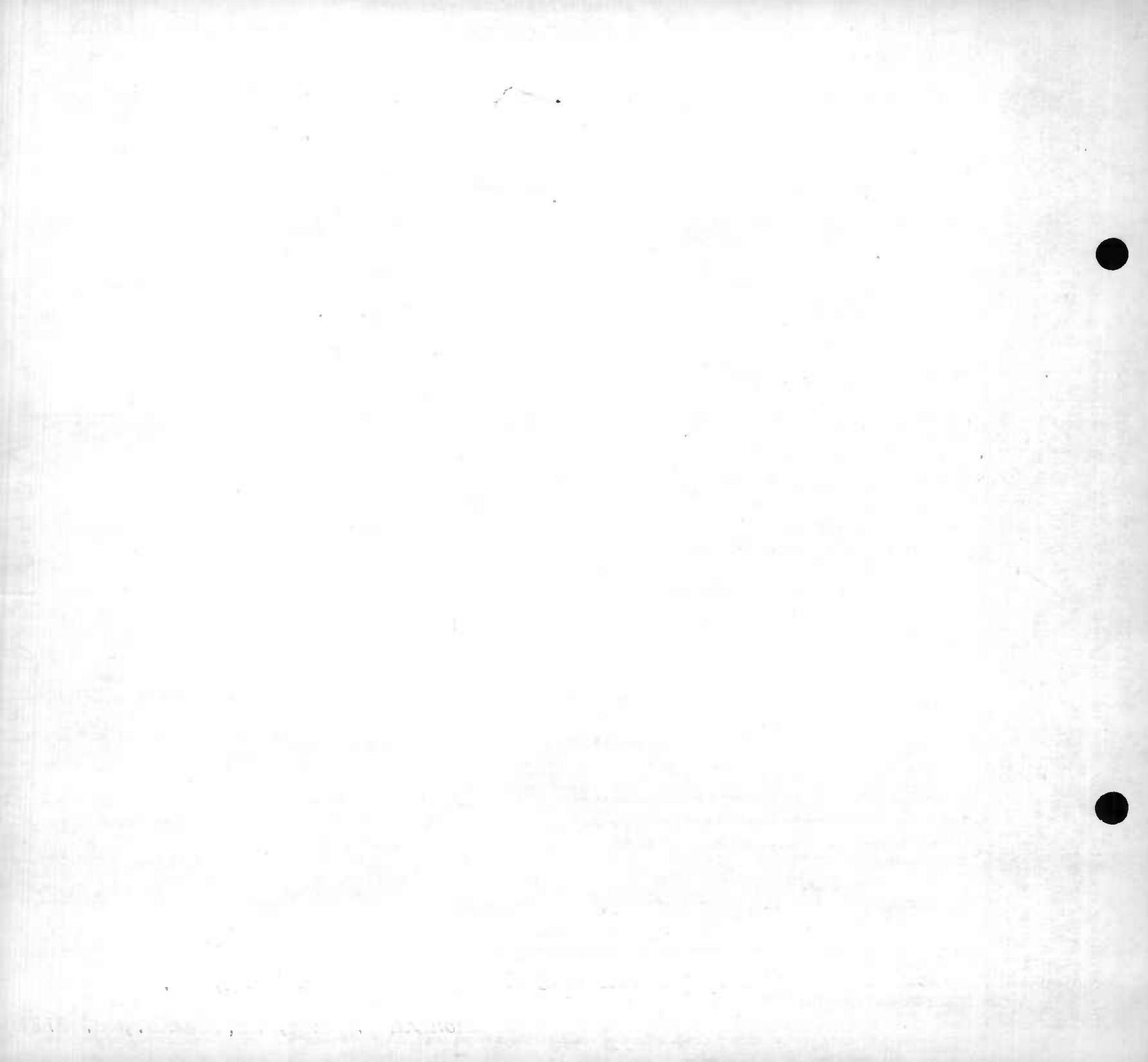
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# FUNERAL DIRECTOR: IMPORTANT

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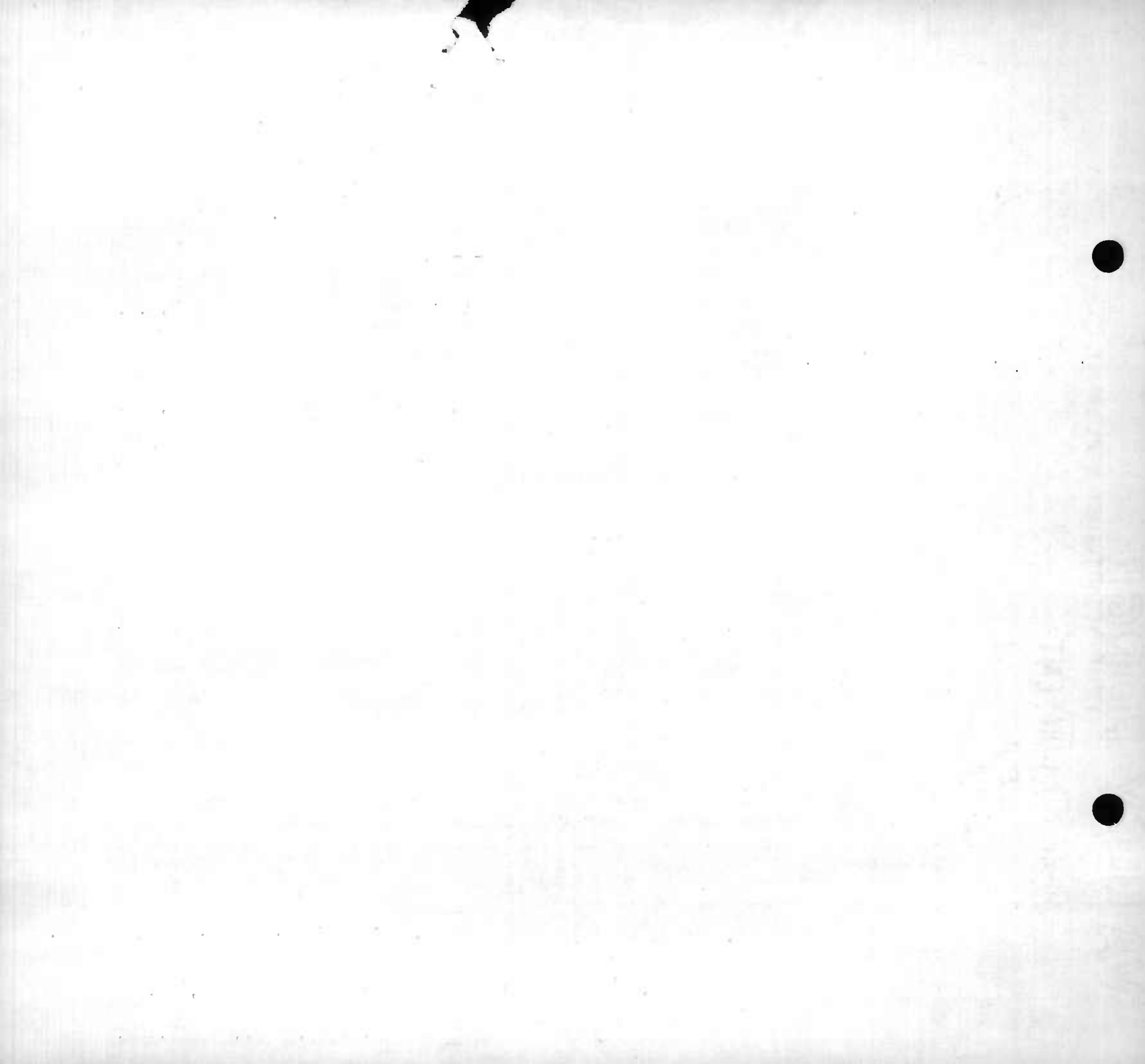
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2968	
BIRTH NO. 65 2968		M.E. CASE NO. 65 2968		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Susan Delane Griffith			2. DATE AND HOUR OF DEATH March 18, 1965 1 8:00 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5718 Eastbury Baltimore, Md.			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Balt. city C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5718 Eastbury		
5. SEX F.	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH 12/24/51	9. AGE (In years last birthday) 13	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Jewel Ridge, Va.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Roy Griffith		
14. MOTHER'S MAIDEN NAME Dorothy Belcher			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) n		
16. SOCIAL SECURITY NO.			17. INFORMANT Mother		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Leukemia DUE TO INTERVAL BETWEEN ONSET AND DEATH ? 8 Yrs.			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/10 19 65 to 3/18 19 65, that (I) (we) last saw the deceased alive on 3/18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Mirkin			23B. DATE SIGNED 3/18/65		
23C. PHYSICIAN'S NAME (Type) G. MIRKIN			23D. ADDRESS M.D. Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/65		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery Baltimore, Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. MAR 19 1965			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. 21214			



# FUNERAL DIRECTOR: IMPORTANT

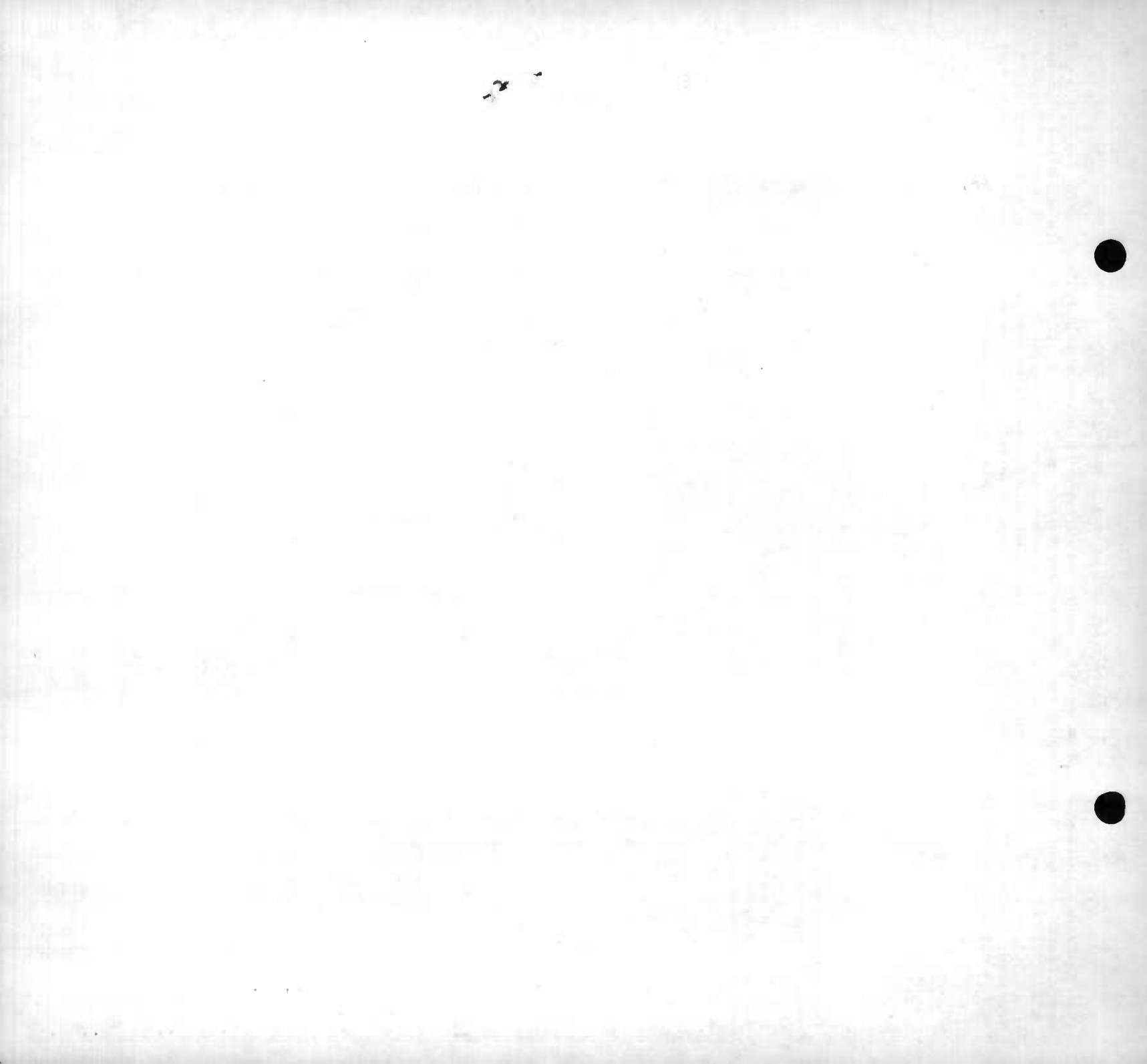
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2969</u>	
BIRTH NO. <u>65 2969</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Staley, Hattie M.</u>		2. DATE AND HOUR OF DEATH <u>March 18 1965</u> <u>7.10P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore #14</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #14</u>			
		D. STREET ADDRESS (If rural, give location) <u>3106 Southern Ave.</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>7-5-1884</u>	9. AGE (In years last birthday) <u>80</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES P. BEALL</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN WILGIS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. CATHERINE MOST, BALTIMORE, MD.</u>	
18. <u>420.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Heart Disease</u> <u>With Congestive Heart Disease</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>March 10 19 65</u> to <u>March 18 19 65</u> , that (I) (we) last saw the deceased alive on <u>March 18 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Rostom D. Rivera</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>March 18 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Rostom D. Rivera</u>		23D. ADDRESS <u>1400 N. Caroline St. Balto. 21213 Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3/22/65</u>		24C. NAME of CEMETERY or CREMATORY <u>MT. ZION CEMETERY</u>	
24D. LOCATION <u>HARFORD COUNTY, MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 19 1965</u>			
25B. NAME OF REGISTRAR <u>Edgar E. Sisk</u>		25C. FUNERAL DIRECTOR <u>LEONARD J. RUCK, INC., BALTO., MD.</u>			



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VS 150-REV. 1/1/65





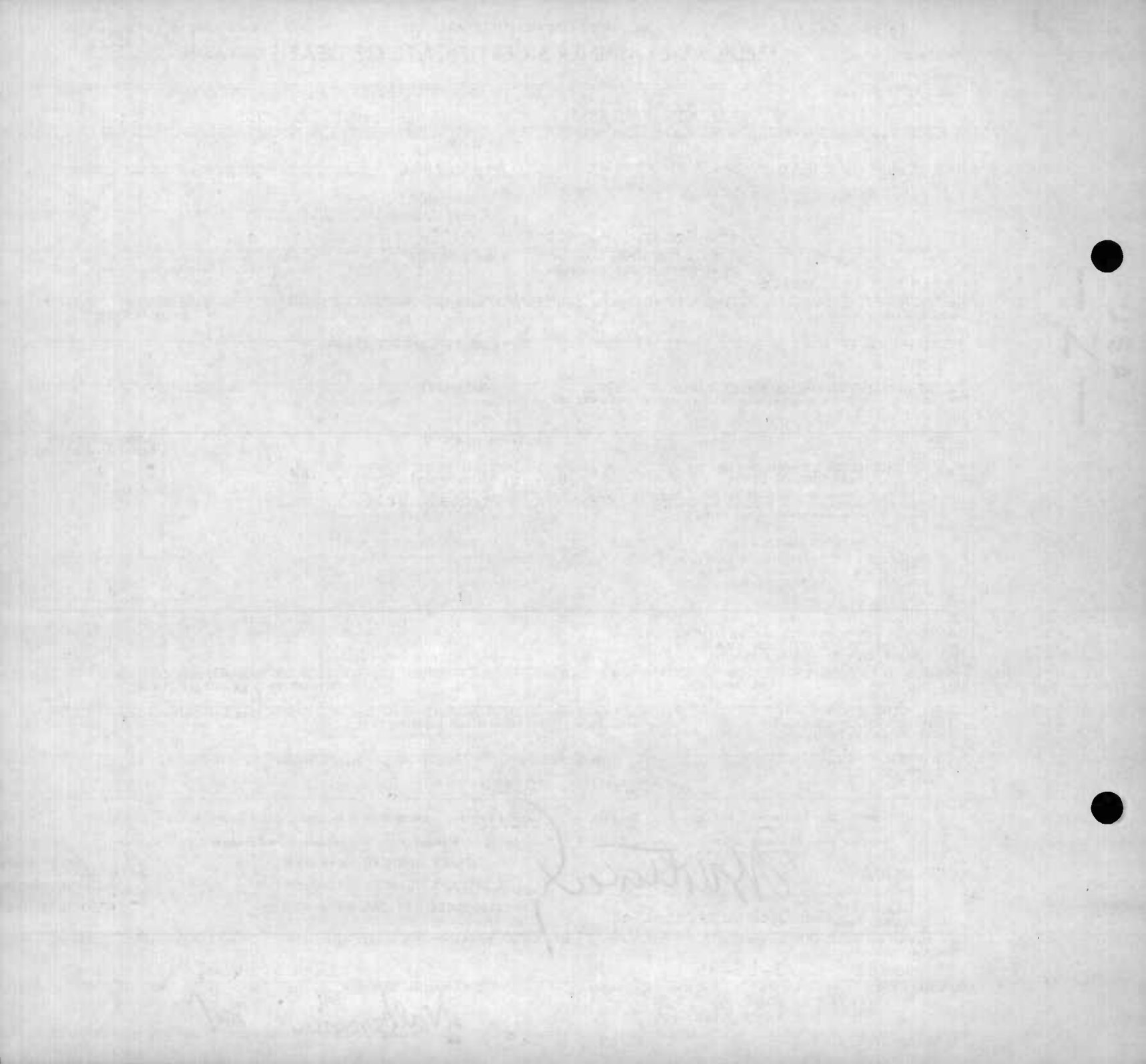
W-516

65 2971

BALTIMORE CITY HEALTH DEPARTMENT

65 2971

BIRTH NO.		<b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>		Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
RUSSELL WINEBRENNER			March 16, 1965 5:20 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  Maryland General Hospital			A. STATE Maryland		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1224 Maryland Avenue		
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) 64	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">I</p> <p style="text-align: center;">Bronchopneumonia and acute</p> <p style="text-align: center;"><del>pyelonephritis</del></p> <p style="text-align: center;">(A)</p> <p style="text-align: center;">DUE TO</p> <p style="text-align: center;">(B)</p> <p style="text-align: center;">(C)</p> <p style="text-align: center;">II</p> <p style="text-align: center;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D.		DATE SIGNED	
EXAMINER'S NAME (Type)				3-17-65	
Rudiger Breitenecker					
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Removal		3-17-65			
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
MAR 19 1965		Robert E. Taylor		G. C. Barton	
				ADDRESS	
				Walkersville, Maryland	



# FUNERAL DIRECTOR: IMPORTANT

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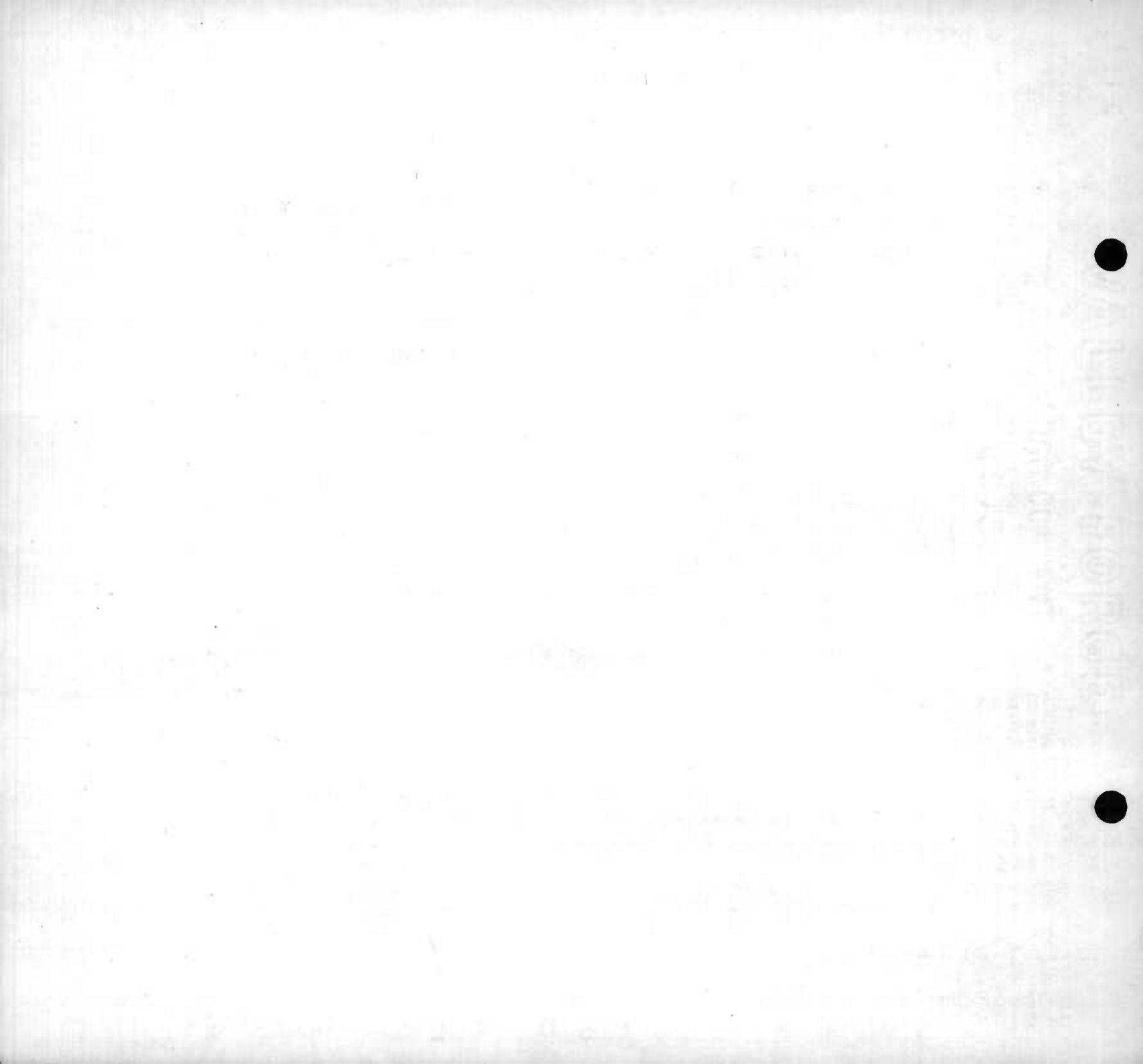
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 2972	
BIRTH NO. 64-10583 65 2972		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) THERESA JOHNSON		2. DATE AND HOUR OF DEATH 3/13/65 4:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 1645 E. EAGER ST. BALTIMORE, MD 21205			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY			
				D. STREET ADDRESS (If rural, give location) 1645 E. EAGER STREET			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 04-29-64	9. AGE (In years last birthday) 10 - - -	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE,		12. CITIZEN OF WHAT COUNTRY? AMERICAN.	
13. FATHER'S NAME CHARLES GENTRY				14. MOTHER'S MAIDEN NAME DORTHEA JOHNSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. 736.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) G.I. BLEEDING DUE TO (B) LIVER CIRRHOSIS DUE TO (C) BILIARY ATRESIA		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS  LIFE	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 33-10-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from MARCH 10 19 65 to MARCH 13 19 65, that (H) (we) last saw the deceased alive on MARCH 13 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph M. Almond, Jr.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/13/65	
23C. PHYSICIAN'S NAME (Type) JOSEPH M. ALMOND, JR.				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE MAR 16 1965		24C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 19 1965		25B. NAME OF REGISTRAR Robert E. Gentry		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	



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BIRTH NO. 65 2973		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 2973	
1. NAME OF DECEASED (Type or Print) THOMAS SIMMONS			2. DATE AND HOUR OF DEATH 3/11/65 1:55 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3123 MC ELDERRY ST		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 7-13-83	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME JAMES			14. MOTHER'S MAIDEN NAME SARAH SCHUMACHER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 204.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Leukemia (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 yr
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2 Nov		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No	
21D. TIME OF INJURY (APPROX.) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? X	
22. I certify that (I) (this hospital) attended the deceased from 2/8 19 65 to 3/11 19 65, that (I) (we) last saw the deceased alive on 3/11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. P. Kolykay			23B. DATE SIGNED 3/11/65		
23C. PHYSICIAN'S NAME (Type) J. P. Kolykay			23D. ADDRESS M.D. BOARD of Health		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE MAR 16 1965		24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. MAR 19 1965		25B. NAME OF REGISTRAR G. E. F. F. F.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	

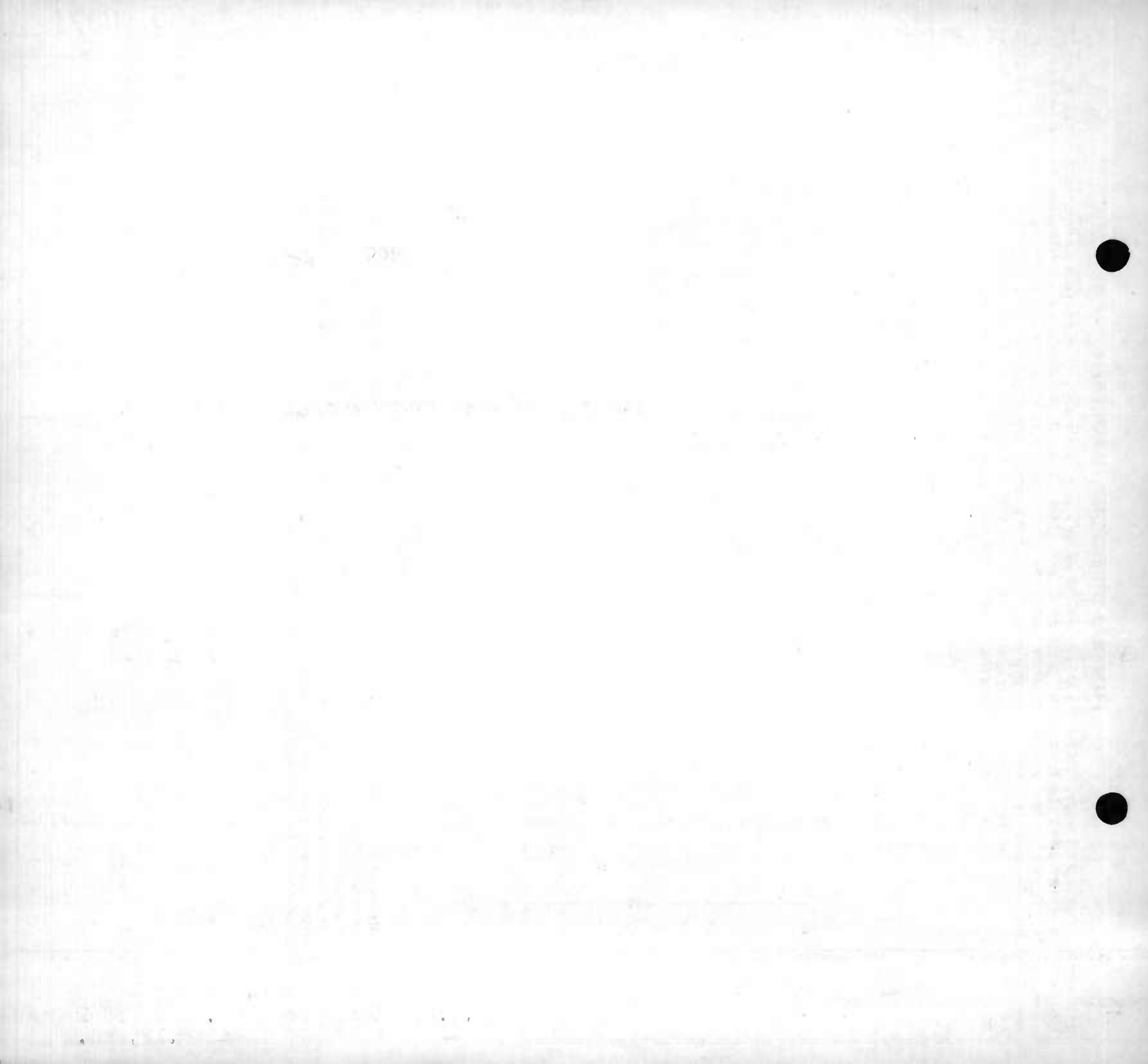


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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2974</u>	
BIRTH NO. <u>65 2974</u>		M.E. CASE NO.		1. NAME OF DECEASED <u>Cole, Mr. Albert B.</u>	
2. DATE AND HOUR OF DEATH <u>3. 18. '65</u>		7. <u>20</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <u>B. COUNTY</u>			
<u>Church Home &amp; Hospital.</u>		<u>451. Ilchester Ave. Balto. 18. MD.</u>			
<u>Fayette &amp; Broadway. Baltimore 31.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		<u>Baltimore.</u>			
		D. STREET ADDRESS (If rural, give location)			
		<u>451. Ilchester. Ave.</u>			
5. SEX <u>M.</u>	6. RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married.</u>	8. DATE OF BIRTH <u>5. 26. 1900</u>	9. AGE (In years last birthday) <u>64 yrs.</u>	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor News America.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>News. American.</u>	11. BIRTHPLACE (State or foreign country) <u>Washington. D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Cole.</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Martin.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>412-09-2944</u>		17. INFORMANT <u>MRS. EDITH A. COLE</u> ADDRESS <u>(SAME)</u>	
18. <u>527.1 I</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <u>Respiratory Acidosis.</u>			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(B) <u>Emphysema.</u>		<u>Few months</u>	
ANTECEDENT CAUSES		(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>Yes.</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>3. 17. 1965</u> to <u>3. 18. 1965</u> , that (I) (we) last saw the deceased alive on <u>3. 18. 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>N. Basu.</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3. 18. 65</u>	
23C. PHYSICIAN'S NAME (Type) <u>NITA BASU</u>		23D. ADDRESS <u>Church Home &amp; Hospital. Balto. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/20/1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore,</u>		(State) <u>Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 19 1965</u>		25B. NAME OF REGISTRAR <u>G. E. Faldutis</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co. 4905 York Road Balto. 12, Md.</u>	

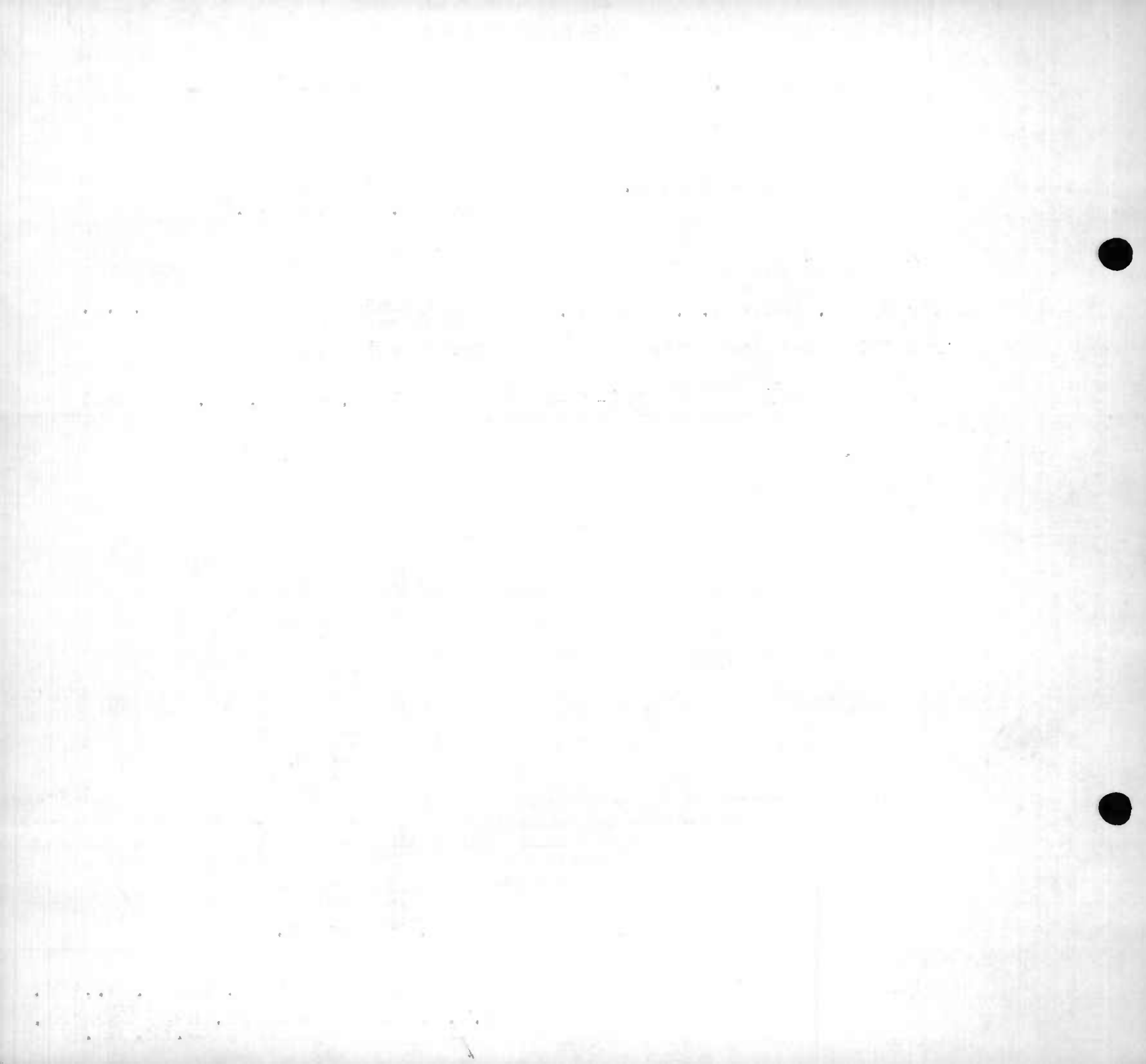




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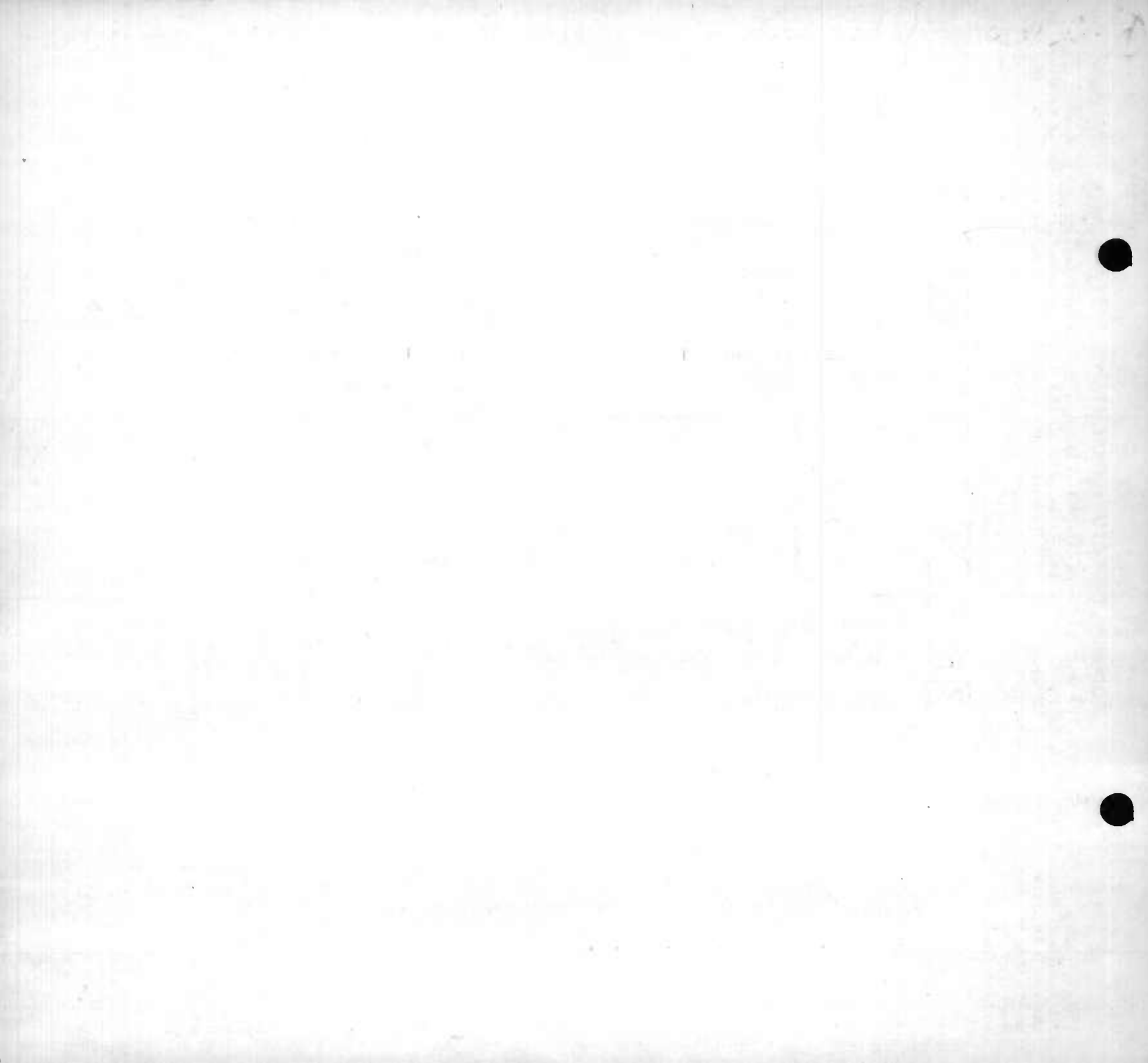
BIRTH NO. 65 2975				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2975	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Granville C. Swope				2. DATE AND HOUR OF DEATH March 18, 1965 1:15 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) Cambridge Arms Apt.				A. STATE Maryland			
				B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 3339 N. Charles St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3/20/1880	9. AGE (In years last birthday) 84	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Ins. Broker G.C. Swope Co.				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Granville Hamilton Swope				14. MOTHER'S MAIDEN NAME Emma Buckingham			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI				16. SOCIAL SECURITY NO. 212-01-0568		17. INFORMANT ADDRESS Granville C. Swope, Jr. (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 527.1 I Pulmonary Embolism years.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>(the hospital)</del> attended the deceased from 3/15 to 3/18 1965, that (I) (we) last saw the deceased alive on 3/18 1965 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE Mark Dugan				23B. DATE SIGNED 3/19/65			
23C. PHYSICIAN'S NAME (Type) Mark Dugan				23D. ADDRESS 15 E. Biddle St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/1965		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 19 1965		25B. NAME OF REGISTRAR E. E. Taylor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

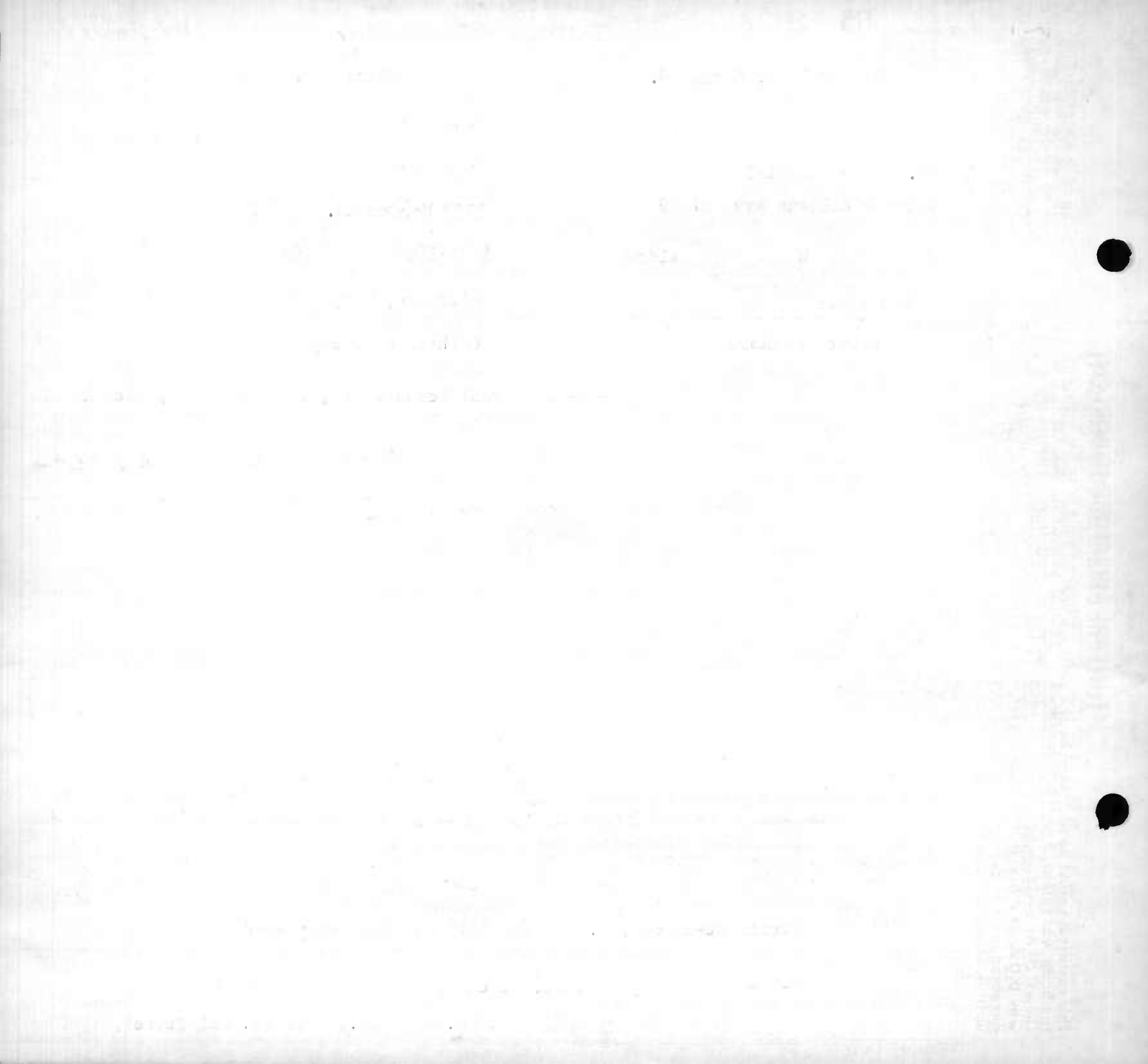
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2976		CERTIFICATE OF DEATH		Registered No. 65 2976	
1. NAME OF DECEASED (Type or Print) <u>Richards, Mollie</u>				2. DATE AND HOUR OF DEATH <u>March 17, 1965</u> <u>13:00</u> pm M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>202</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>109 S. Register St.</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1/19/79</u>	9. AGE (In years last birthday) <u>86</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>GEORGE CHEWNING</u>				14. MOTHER'S MAIDEN NAME <u>JENNIE LUMPSDON</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>GRACE NEWMAN</u>				ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>493X - 1 260X</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <u>Pneumococcal Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<u>ASCVD with CHF, Diabetes, Myxedema</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <del>XXXXXX</del> attended the deceased from <u>3/17</u> 19 <u>65</u> to <u>3/17</u> 19 <u>65</u> , that (I) <del>XXXXXX</del> saw the deceased alive on <u>3/17</u> 19 <u>65</u> and that in (my) <del>XXXXXX</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>XXXXXX</del> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>John F. Bigger, Jr. MD</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3-17-65</u>			
23C. PHYSICIAN'S NAME (Type) <u>John F. Bigger, Jr., M.D.</u>				23D. ADDRESS <u>Johns Hopkins Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3/20/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>RHOADESVILLE CHURCH CEMETERY</u>			24D. LOCATION (City, town, or county) (State) <u>RHOADESVILLE VIRGINIA</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 19 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Stoddy</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook Inc. 1217 S. Park St. 21202</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2977</u>	
BIRTH NO. <u>65 2977</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Reinsfelder, Elsie G.</u>		2. DATE AND HOUR OF DEATH <u>March 18, 1965</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Agnes Hospital</u> <u>Caton &amp; Wilkens Ave 21229</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>2712 Norfen Rd. 21227</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>1/25/1896</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Samuel Connors</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Dorsey</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-12-0229</u>		17. INFORMANT ADDRESS <u>Paul Reinsfelder, 2712 Norfen Rd, Balto 21227</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Coronary Thrombosis</u> DUE TO (B) <u>Hypertensive C-V Disease</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>10 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 10 1958</u> to <u>March 18 1965</u> , that (I) (we) last saw the deceased alive on <u>March 15 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Morris Steinberg</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3/19/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Morris Steinberg, M.D.</u>		23D. ADDRESS <u>3913 Hollins Ferry Road</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-22-65</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 19 1965</u>		25B. NAME OF REGISTRAR <u>Wm Cook, Inc.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>1217 St. Paul Street, 21202</u>	





65 2978

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2978

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JUDITH L. CARRICK

2. DATE AND HOUR PRONOUNCED DEAD

March 18, 1965 4:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Timonium

D. STREET ADDRESS (If rural, give location)

206 Brightdale Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

February 25, 1943

9. AGE (In years  
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Typist-Clerk

10B. KIND OF BUSINESS OR INDUSTRY

McCormick Company

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George H. Carrick

14. MOTHER'S MAIDEN NAME

Irma M. Stahl

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

214-44-8591

17. INFORMANT

ADDRESS

Mrs. Irma Carrick, 206 Brightdale Rd, TIMONIUM, Md

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Doriden Intoxication.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

206 Brightdale Road

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
3 15 '65

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Overdose of Doriden

22.

I certify that, I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/18/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

3-20-65

23C. NAME of CEMETERY or CREMATORY

Dulaney Valley Memorial

23D. LOCATION

(City, town, or county)

Baltimore County, Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 19 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Towson, Inc., 1050 York Road, 21204

Chambers



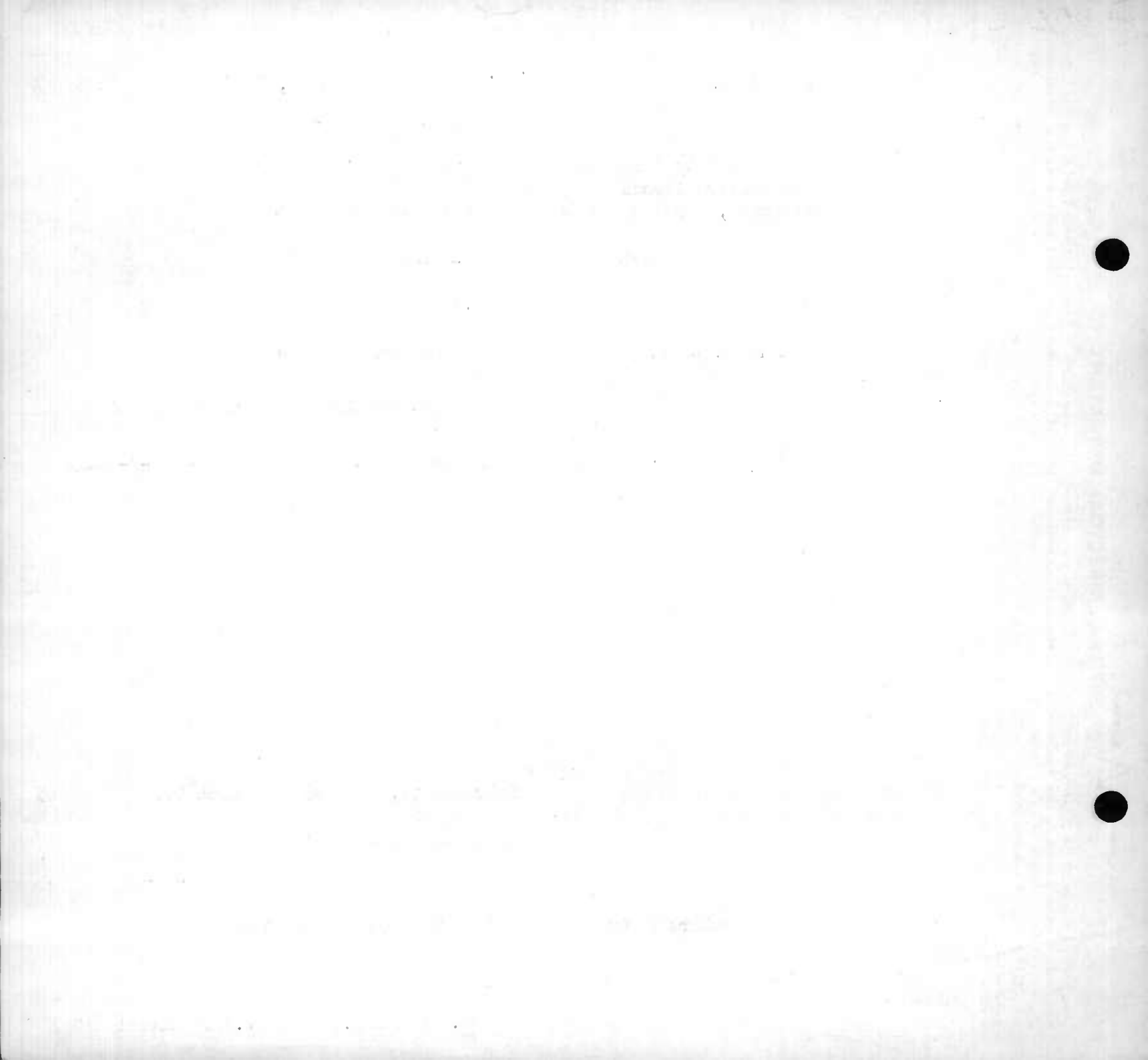
VALLEY POLICE

*[Handwritten signature]*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2980		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2980	
1. NAME OF DECEASED (Type or Print) Emma Coursey			2. DATE AND HOUR OF DEATH March 17, 1965 7:35 AM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-12 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4940 Eastern Avenue		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 12-25-86	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John W. Coursey		
14. MOTHER'S MAIDEN NAME Ida May Griffith			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue #24		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia 2-3- days			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 17, 1936 to March 17, 1965, that (I) (we) last saw the deceased alive on March 17, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Cooke			23B. DATE SIGNED 3-17-65		
23C. PHYSICIAN'S NAME (Type) Robert Cooke			23D. ADDRESS M.D. 4940 Eastern Avenue 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-22-65		24C. NAME of CEMETERY or CREMATORY Western Cemetery	
24D. LOCATION Baltimore		24E. DATE REC'D BY HEALTH DEPT. MAR 19 1965			
25A. NAME OF REGISTRAR Wm Cook		25B. FUNERAL DIRECTOR ADDRESS 1217 St. Paul Street, 21202			



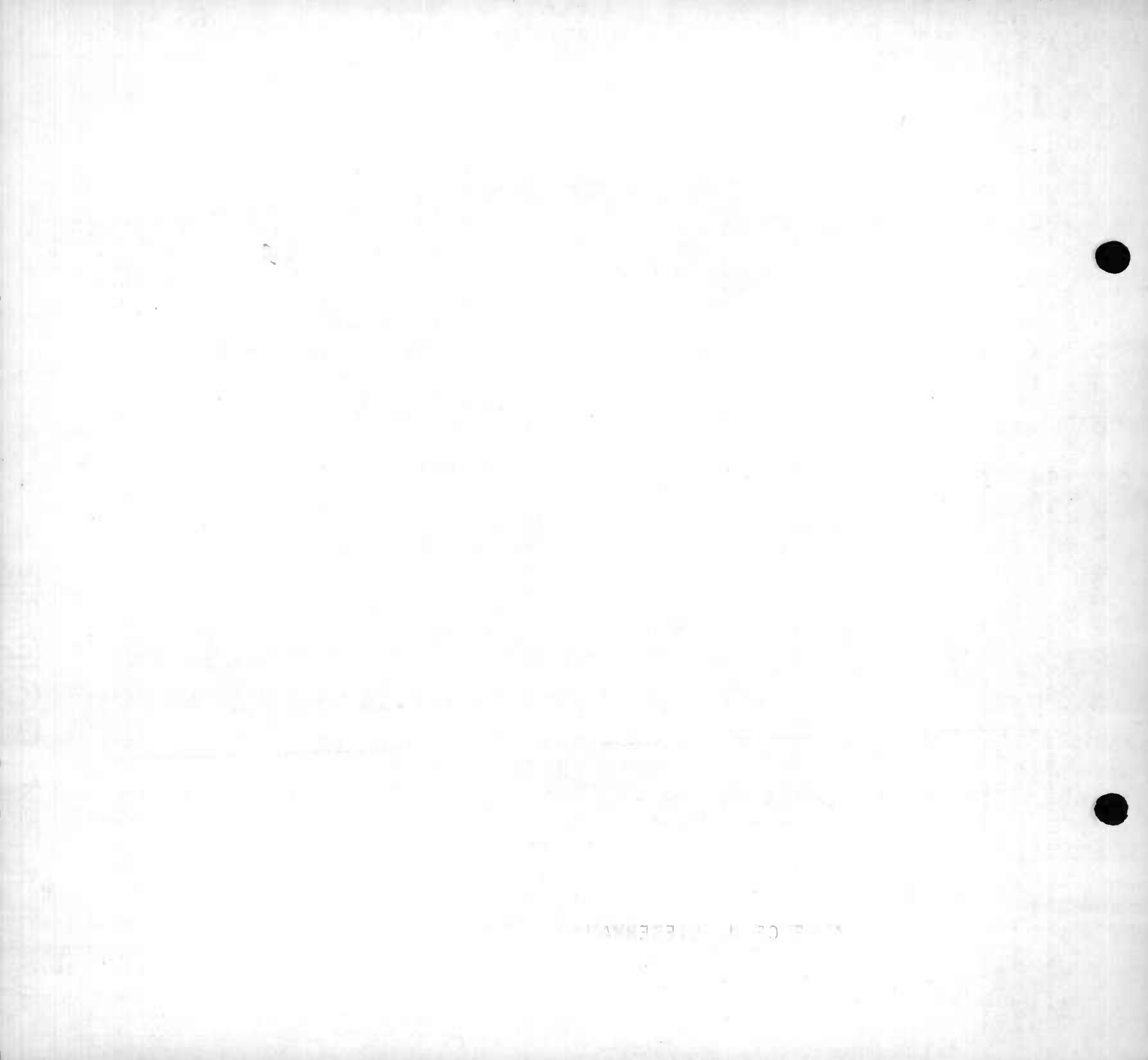


# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>65 2981</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 2981</b>	
1. NAME OF DECEASED (Type or Print) <b>Mary Louise Emery</b>			2. DATE AND HOUR OF DEATH <b>3-17-65</b>   <b>1:30</b> <b>A</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>12 02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>3049 GUILFORD AVE.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>3-17-74</b>	9. AGE (In years last birthday) <b>90</b>	If Under 1 Yr. Months Days Hours Min. <b>60 - 15 - 00</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>FREDERICK WENNAGLE</b>		
14. MOTHER'S MAIDEN NAME <b>LOUISA UNKNOWN</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>		
16. SOCIAL SECURITY NO. <b>-</b>			17. INFORMANT ADDRESS <b>chart - Union Memorial Hospital</b>		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CORONARY Thrombosis</b> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSclerotic Cardio- Vascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>Years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0 -</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>-</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (1) (this hospital) attended the deceased from <b>3-11-1965</b> to <b>3-17-1965</b> , that (1) (we) last saw the deceased alive on <b>3-17-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Lawrence J. Lieberman</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>3-17-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>LAWRENCE J. LIEBERMAN</b> M.D.				23D. ADDRESS <b>1400 EUTAW PLACE BALTO, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-19-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>LOUDON PARK</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 22 1965</b>			
25B. NAME OF REGISTRAR <b>W. E. Salyer</b>		25C. FUNERAL DIRECTOR <b>JOHN D. MITCHELL &amp; SONS, INC.</b>			
25D. ADDRESS <b>1400 EUTAW PLACE BALTO, M.D.</b>					





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

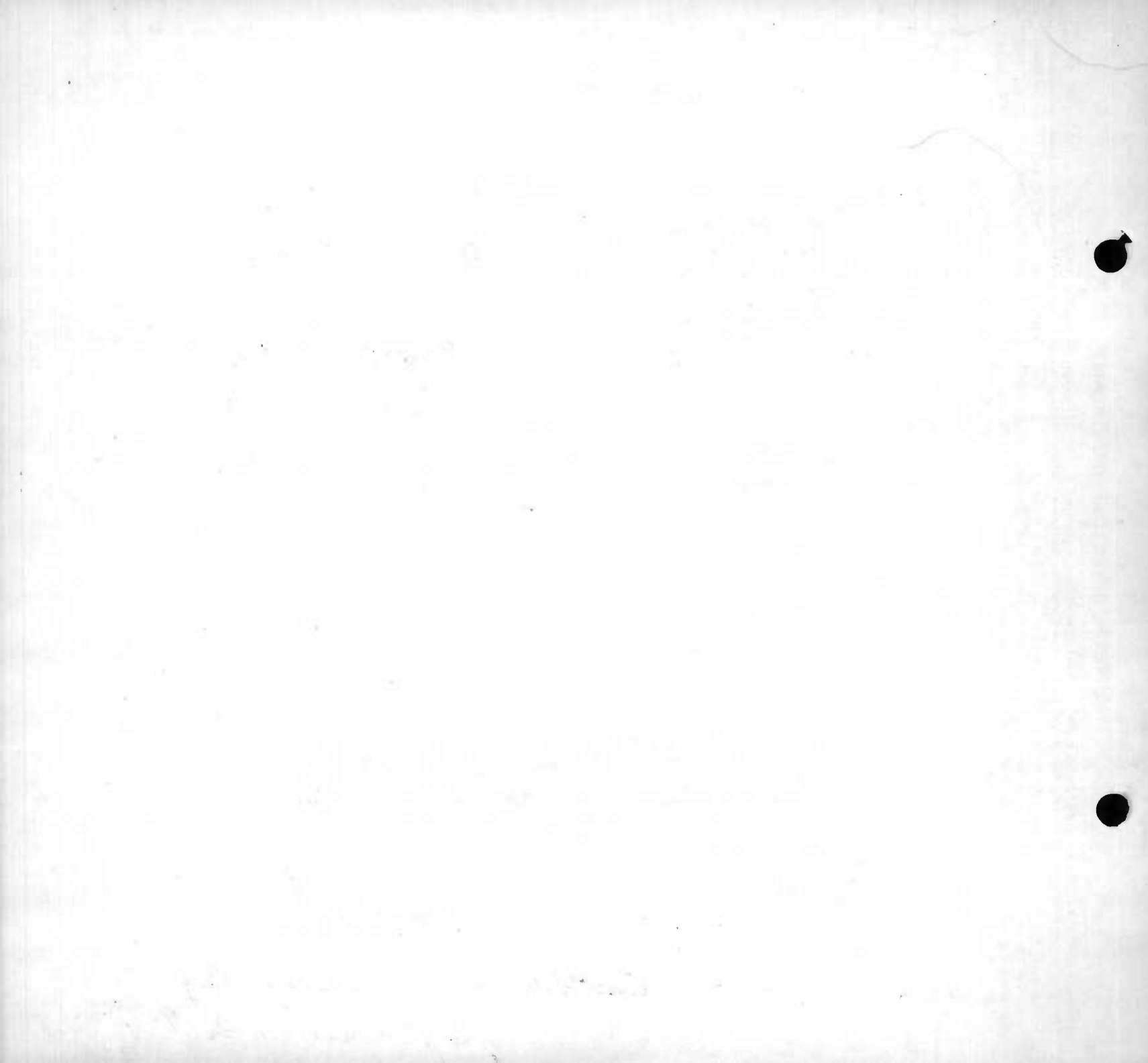
BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 2982					CERTIFICATE OF DEATH					Registered No. 65 2982									
1. NAME OF DECEASED (Type or Print) <b>CHARLES BOND</b>					2. DATE AND HOUR OF DEATH <b>3-17-65 10.06 P.M.</b>														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>A.A. COUNTY</b>														
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>GLENBURNIE 52-00</b>														
					D. STREET ADDRESS (If rural, give location) <b>646 NEW JERSEY AVE</b>														
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>10-25-86</b>		9. AGE (In years last birthday) <b>78</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>Baltimore County, Md.</b>					12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>JOHN BOND</b>					14. MOTHER'S MAIDEN NAME <b>CARRIE BLATTENBERGER</b>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>212-01-4933</b>		17. INFORMANT <b>Edna G. Bond Glen Burnie, Md.</b>					ADDRESS <b>646 New Jersey Ave (Wife)</b>							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>153.81 Carcinoma of Colon</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3-5 yrs.</b>									
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(A) DUE TO									
										(B) DUE TO									
										(C) DUE TO									
II																			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION <b>2</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>Yes</b>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that <del>N</del> (this hospital) attended the deceased from <b>3/9</b> 19 <b>65</b> to <b>3/12</b> 19 <b>65</b> , that <del>N</del> (we) last saw the deceased alive on <b>3/12</b> 19 <b>65</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>N</del> (We) (did) (did not) view the body after death. <b>10:06 PM</b>																			
23A. SIGNATURE <b>Virgil Brown</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <b>3/12/65</b>									
23C. PHYSICIAN'S NAME (Type) <b>VIRGIL BROWN</b>					M.D. 23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>														
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>3-20-65</b>					24C. NAME of CEMETERY or CREMATORY <b>Saters Baptist Church Cemetery</b>					24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 22 1965</b>					25B. NAME OF REGISTRAR <b>Charles E. Haskins</b>					25C. FUNERAL DIRECTOR <b>Edna G. Seitz</b>					ADDRESS <b>5209 York Road Balto. Md. 21212</b>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 2983		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2983	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) AKERS, HATTIE MINNIE		2. DATE AND HOUR OF DEATH March 17, 1965 10 <sup>12</sup> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4X Maryland University Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE USA B. COUNTY 21-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 821 Maryland St. Balto. 30			
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4-21-08	9. AGE (In years last birthday) 56	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembly Line Bendix Co.		10B. KIND OF BUSINESS OR INDUSTRY W. Virginia		11. BIRTHPLACE (State or foreign country) W. Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Groner E. Tyree		14. MOTHER'S MAIDEN NAME Angie Griner	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service) -		16. SOCIAL SECURITY NO. 216-18-3624		17. INFORMANT Peter Akers Sr. Sp. Address above	
18. 171X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO O Ca-7 cervix stage IAB 2 years (B) DUE TO C Constrictive heart failure 6 days (C) _____		INTERVAL BETWEEN ONSET AND DEATH 2 years 6 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 15 1965 to March 17 1965, that (I) (we) last saw the deceased alive on March 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chee Fai Tse		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-17-65	
23C. PHYSICIAN'S NAME (Type) CHEE FAI TSE		23D. ADDRESS Maryland University Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/65		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cem.	
24D. LOCATION (City, town, or county) (State) Kitchie Hwy Md.					
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1965		25B. NAME of REGISTRAR E. Stokum		25C. FUNERAL DIRECTOR J. G. Gorman & Son Inc. 901 Hollins St. 23 Md.	



K-4001

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 2984

BIRTH NO. 65 2984		M.E. CASE NO. L.	
1. NAME OF DECEASED (Type or Print) GRACE KELL		2. DATE AND HOUR OF DEATH 3/17/65 8 45 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00 D. STREET ADDRESS (If rural, give location) 19 HARRISON AVE	
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH June 1, 1878
9. AGE (In years last birthday) 86		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Fillingner		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT H. Alton Kell, Jr. Route 16 Box 384A Columbia Rd. Balt. 20		ADDRESS	
18. 450.0 x 1260 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES Mellitus			
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from MARCH 8 19 65 to MARCH 17 19 65, that (I) (we) last saw the deceased alive on MARCH 17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John Howard Lutz M.D.		23B. DATE, SIGNED 3/17/65	
23C. PHYSICIAN'S NAME (Type) John Howard Lutz M.D.		23D. ADDRESS 1502 Shadyside Road	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/20/65	
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery Balt. Md.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1965		25B. NAME OF REGISTRAR John E. Stahler	
25C. FUNERAL DIRECTOR John E. Stahler		25D. ADDRESS 8728 Liberty Rd. Randallstown, Md.	

General and Antislavery

March 17 1842

John Howard

General and Antislavery

March 17 1842

No

No

March 17 1842

John Howard

March 17 1842

John Howard



BIRTH NO. *65 2985* MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. *65 2985*

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Michael W. Wood

2. DATE AND HOUR PRONOUNCED DEAD

March 19, 1965

2:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Montgomery

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Rockville

D. STREET ADDRESS (If rural, give location)

302

224 N. Adams Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Newer married

8. DATE OF BIRTH

Oct. 10, 1961

9. AGE (In years  
last birthday)

3

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Samuel Dayton Wood

14. MOTHER'S MAIDEN NAME

Nellie Frances Calhoun

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

father

ADDRESS

Samuel D. Wood

Same as Item 4.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Rheumatic myocarditis  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m. WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 20, 1965

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

MAR - 3-22-65

23C. NAME OF CEMETERY or CREMATORY

Laytonsville Cemetery

23D. LOCATION

(City, town, or county)

(State)

Laytonsville, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 22 1965

24B. NAME OF REGISTRAR

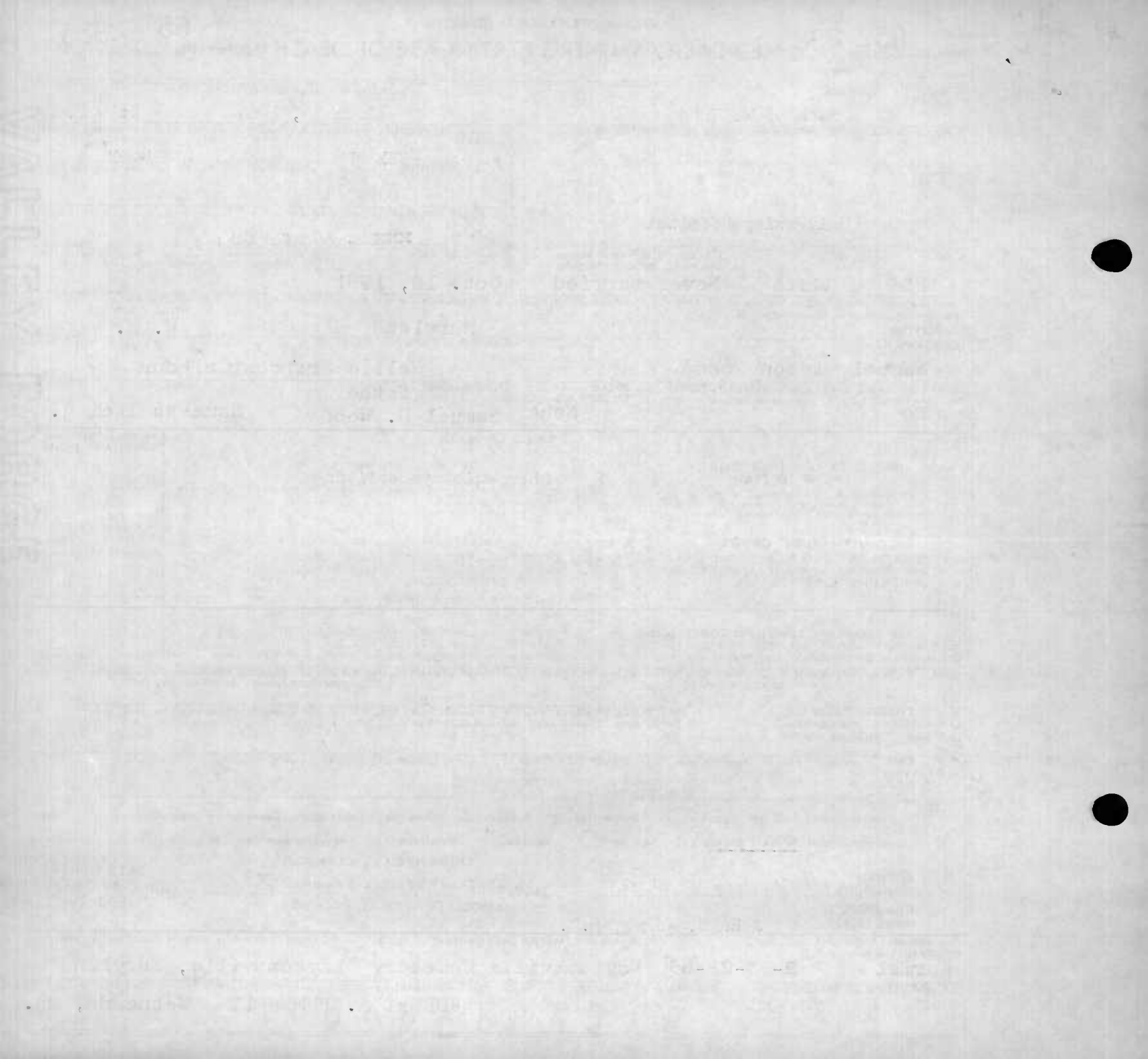
John E. Adams, M.D.

24C. FUNERAL DIRECTOR

ROBERT A. PUMPHREY

ADDRESS

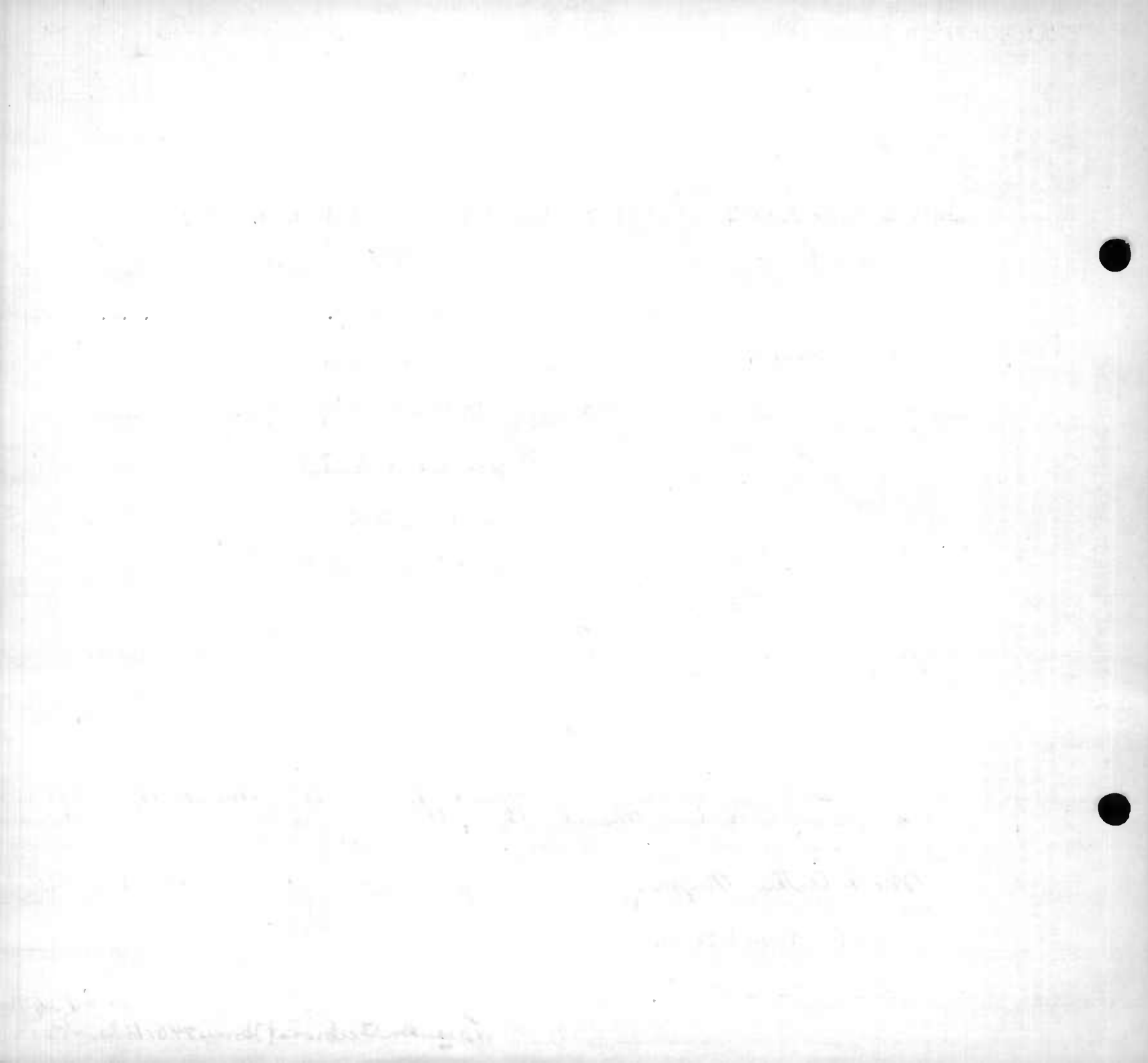
Bethesda, Md.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 2986		CERTIFICATE OF DEATH		Registered No. 65 2986	
1. NAME OF DECEASED (Type or Print) <u>Pearl Gruebl</u>				2. DATE AND HOUR OF DEATH <u>March 18, 1965</u> <u>7:50</u> <u>P.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		B. COUNTY <u>Balto</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>White Marsh</u>				D. STREET ADDRESS (If rural, give location) <u>Red Lion Rd Box 1003</u>					
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>8-27-97</u>		9. AGE (In years last birthday) <u>67</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JOHN SCHMIDT</u>				14. MOTHER'S MAIDEN NAME <u>MAGGIE BEAN</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr Joseph Bruebl</u>			ADDRESS <u>Red Lion Road White M</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>				CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>None</u>				(A) DUE TO			(B) DUE TO		
				(C) DUE TO			(D) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>None</u>									
19A. DATE OF OPERATION <u>Feb. 5, 1965</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Vesicovaginal fistula</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that <del>(#)</del> (this hospital) attended the deceased from <u>March 8, 1965</u> to <u>March 18, 1965</u> , that <del>(#)</del> (we) last saw the deceased alive on <u>March 18, 1965</u> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(#)</del> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Mark Arthur Neyman</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>March 18, 1965</u>			
23C. PHYSICIAN'S NAME (Type) <u>MARK ARTHUR NEYMAN</u>				23D. ADDRESS <u>Md.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-22-1965</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Paul's Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 22 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Lagoon Funeral Home</u>		ADDRESS <u>7401 B. Bain Road</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 2987</u>	
BIRTH NO. <u>65 2987</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Myrtle Baugher</u>		2. DATE AND HOUR OF DEATH <u>3-19-65</u> <u>4:30 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hosp.</u>		A. STATE <u>Maryland</u> B. COUNTY <u>26-01</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> #21206			
		D. STREET ADDRESS (If rural, give location) <u>6000 Eurith Avenue</u>			
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>9-20-1892</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wm Scott Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Sullivan</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>Mr Raymond Thoms 6008 Eurith Avenue #6</u>	
18. <u>4-20-11</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Acute Myocardial Infarct</u>		<u>5 days</u>	
ANTECEDENT CAUSES		(B) <u>Severe Anemia</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		founder			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>3-18</u> 19 <u>65</u> to <u>3-19</u> 19 <u>65</u> , that <del>the</del> (we) last saw the deceased alive on <u>3-19</u> 19 <u>65</u> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edgar V. McGinley</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/19/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Edgar V. McGinley</u>		23D. ADDRESS M.D. <u>South Baltimore General Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>3-22-1965</u>	24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 22 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Assaulted Funeral Home 7401 Belair Road</u>	

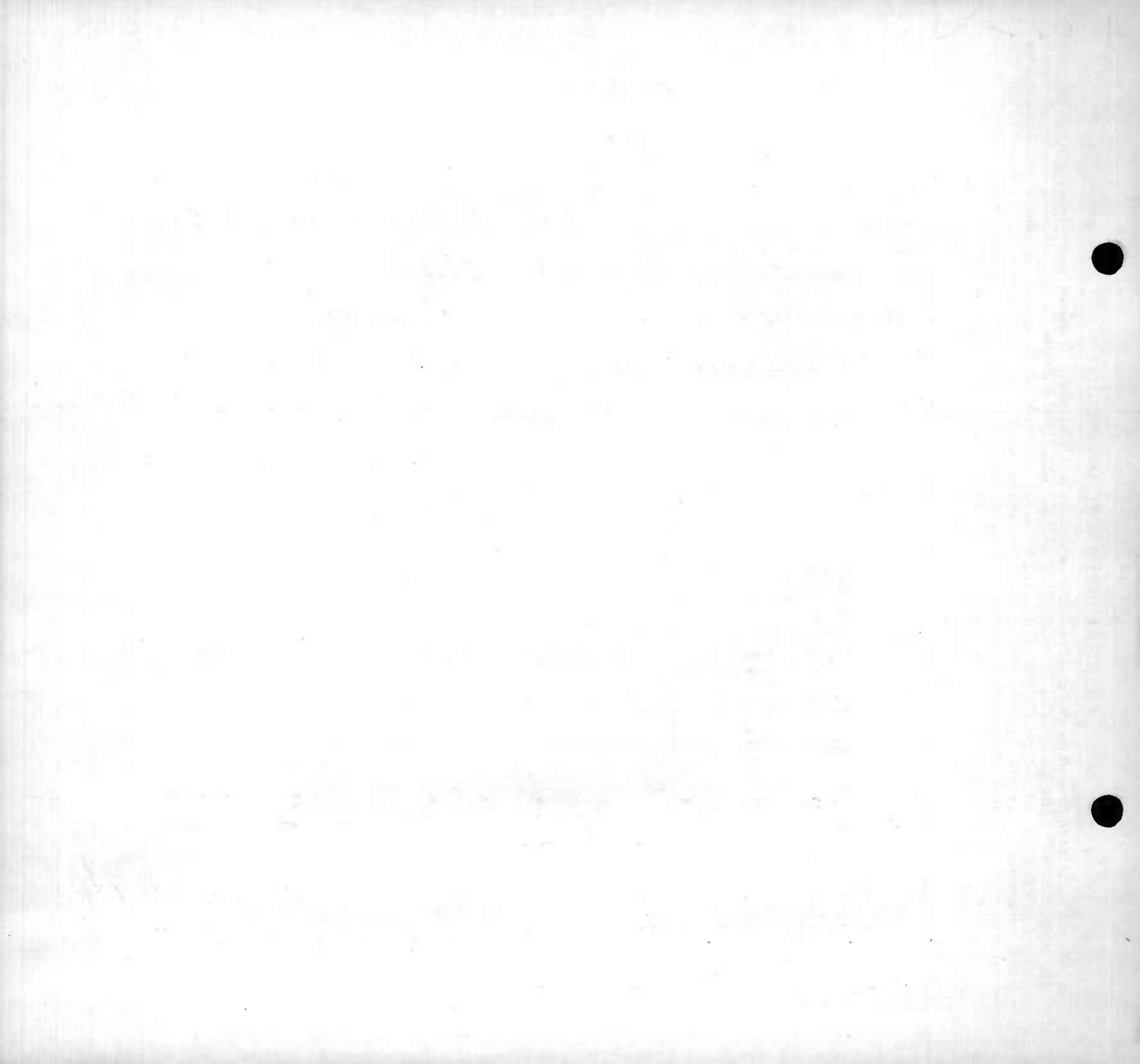


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2988	
BIRTH NO. 65 2988		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Margaret Arbaugh		2. DATE AND HOUR OF DEATH 3/19/65 5:40 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 13-06		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital		D. STREET ADDRESS (If rural, give location) 3302 Elm Ave.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12/3/00	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ambrose Wilbert		14. MOTHER'S MAIDEN NAME Ida M. Lindeman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, ne or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 316-10-7279		17. INFORMANT ADDRESS WALTER NORRIS 3202 ELM AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardiac Arrest CVA		INTERVAL BETWEEN ONSET AND DEATH 4 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3/15 1965 to 3/19 1965, that (we) lost saw the deceased alive on 3/19 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE William B. Long		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/19/65	
23C. PHYSICIAN'S NAME (Type) DR. WILLIAM B. LONG		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-22-65		24C. NAME of CEMETERY or CREMATORY BALTO. NATIONAL	
24D. LOCATION (City, town, or county) (State) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. MAR 22 1965		25B. NAME OF REGISTRAR Paul E. Stokely	
25C. FUNERAL DIRECTOR Paul E. Stokely		25D. ADDRESS 1336 S. 36th St. Annapolis			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

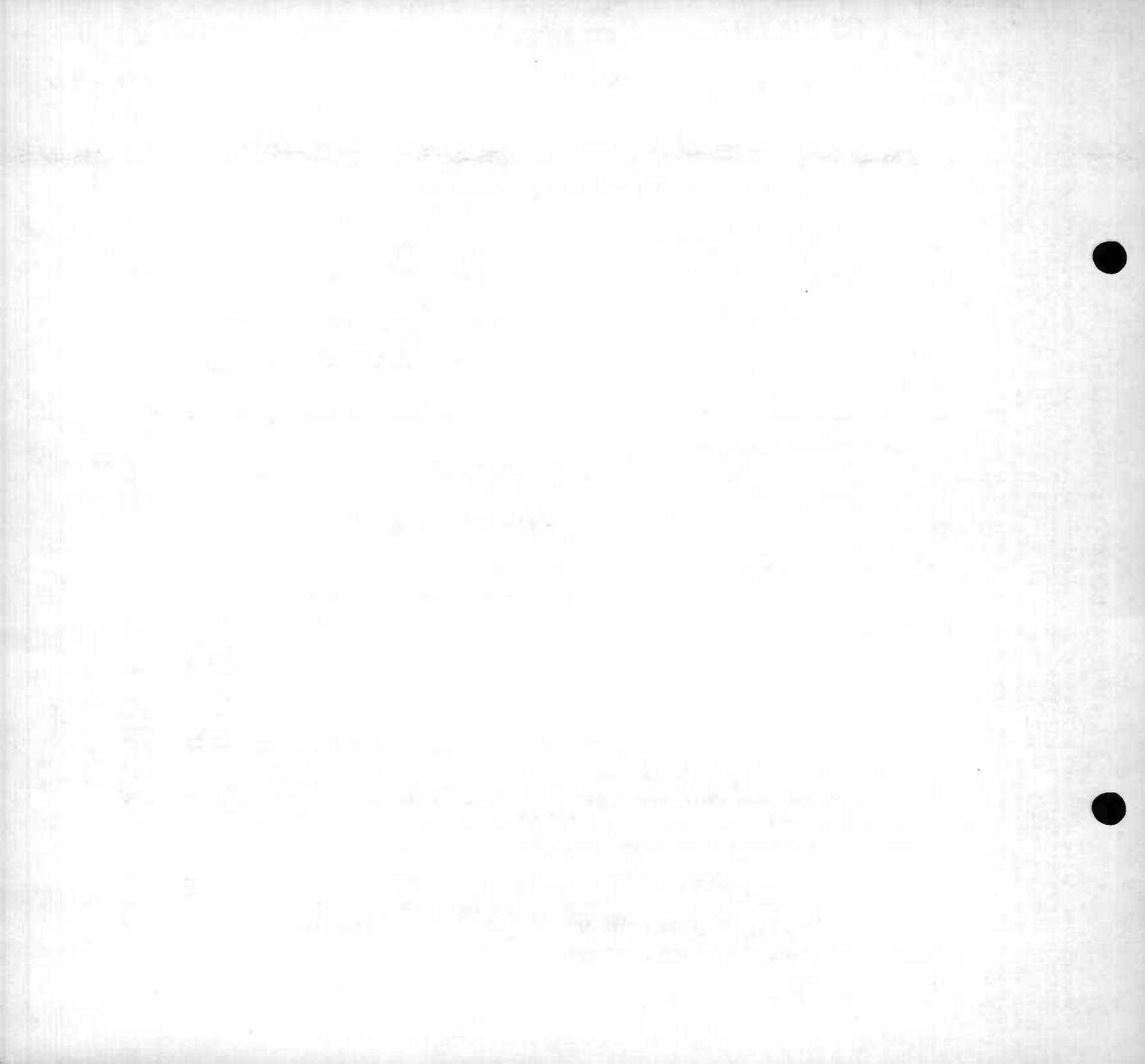
BIRTH NO. 65 2989		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2989	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) William E. McCracken			2. DATE AND HOUR OF DEATH 3-17-65 7:55 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 24-04		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1827 Belt St.		
5. SEX M.	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-23-1883	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Dept. of Education		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert McCracken			14. MOTHER'S MAIDEN NAME Anna L.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Family - Same
18. 422-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3-16 19 65 to 3-17 19 65, that (we) last saw the deceased alive on 3-17 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sherwood Ewell Wilson, M.D.			23B. DATE SIGNED 3-18-65		
23C. PHYSICIAN'S NAME (Type) SHERWOOD EWELL WILSON, M.D.			23D. ADDRESS South Balto. Gen. Hosp. - 1213 Light St.		
24A. BURIAL CREMATION, REMOVAL (Specify) B		24B. DATE 3-20-65		24C. NAME OF CEMETERY or CREMATORY Meadowridge	
24D. LOCATION 13A 1 To.		24E. DATE REC'D BY HEALTH DEPT. MAR 22 1965		24F. NAME OF REGISTRAR Glen E. Talbot	
24G. FUNERAL DIRECTOR McCully		24H. ADDRESS 130 E. Fort Ave. City 30			

215/01  
215/01  
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

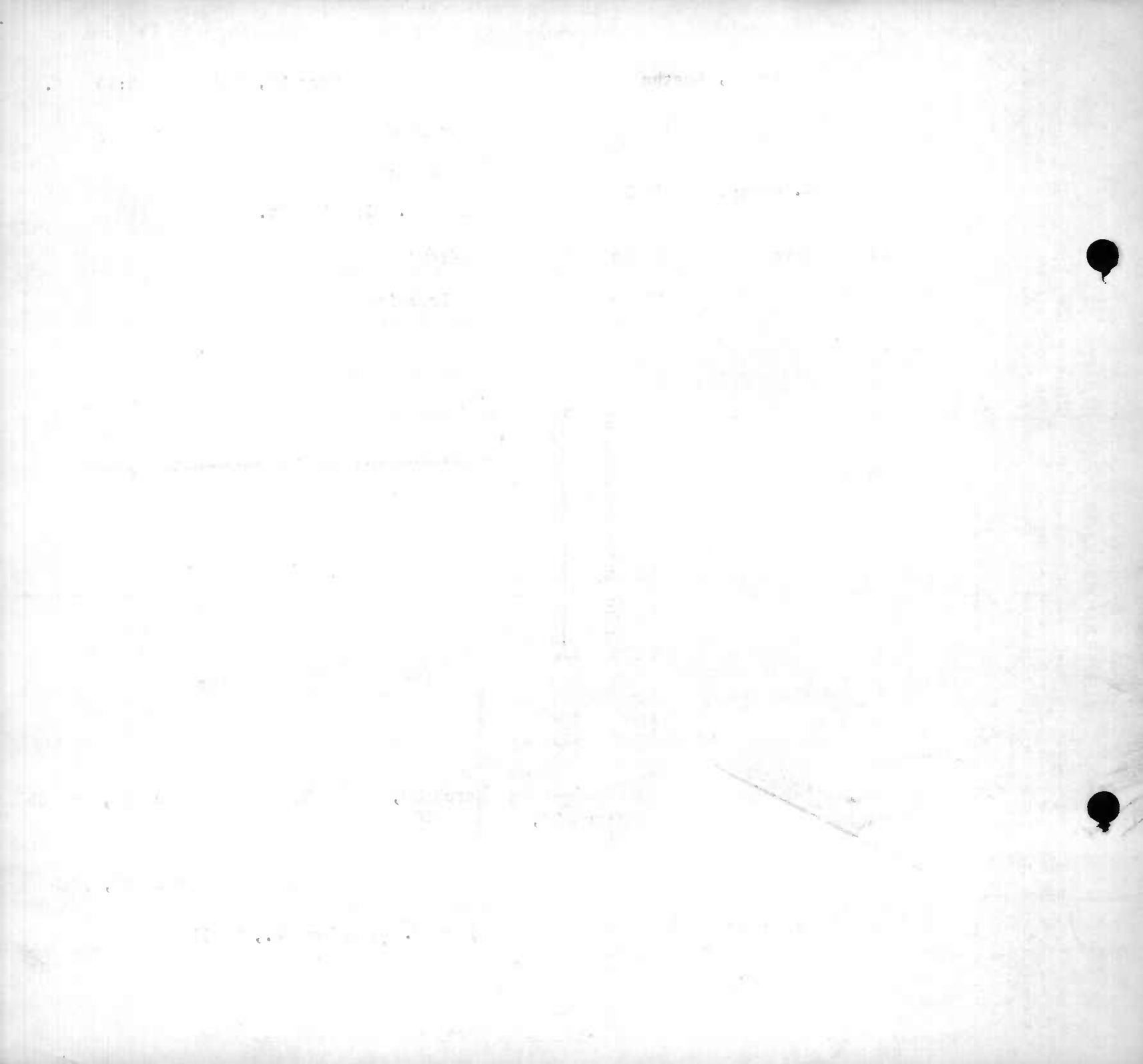
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 2990	
BIRTH NO. 65 2990		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BAER - EUGENE</b>		2. DATE AND HOUR OF DEATH <b>3/20/65 9:40 AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>28-41</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI - HOSPITAL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>4805 BELLE - AVE. #7</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>7/13/98</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ADOLF</b>			14. MOTHER'S MAIDEN NAME <b>THERESE SPIER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>HEANIC BAER 4805 BELLE AVE</b>		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>593X I</b>		CAUSE OF DEATH <b>UREMIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Weeks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO <b>Glomerulonephritis</b>			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2/24/65</b> 19 to <b>3/20/65</b> 19, that (I) (we) last saw the deceased alive on <b>3/20/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Arón Ary</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/20/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>ARON - ARY</b>		23D. ADDRESS <b>SINAI - HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-21-65</b>		24C. NAME of CEMETERY or CREMATORY <b>CHEYRA AHAVAS CHESED</b>	
24D. LOCATION (City, town, or county) (State) <b>RANDALLSTOWN MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 22 1965</b>		25B. NAME OF REGISTRAR <b>Lab E. Sullivan</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Joseph J. Lewis Inc 2100 E. Main Pl.</b>	



## FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 2991				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2991	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Darden, Leatha</b>				2. DATE AND HOUR OF DEATH <b>March 20, 1965 6:40 A. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Joseph Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>9-09</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>1819 N. Aisquith St.</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>8/2/20</b>	9. AGE (In years last birthday) <b>44</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FLOYD PARDEN</b>				14. MOTHER'S MAIDEN NAME <b>ZEPHER TERRY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MAYBELLE JACOBS - 1409 E. LA FAYETTE AVE.</b>		ADDRESS	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MASSIVE INTRACEREBRAL HEMORRHAGE</b>				CAUSE OF DEATH <b>Massive intracerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>March 20, 19 65</b> to <b>March 20, 19 65</b> , that (I) (we) last saw the deceased alive on <b>March 20, 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>J. Towfighi</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>March 20, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Javad Towfighi</b>				23D. ADDRESS M.D. <b>1400 N. Caroline St., 21213</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-24-65</b>		24C. NAME of CEMETERY or CREMATORY <b>MT. CALVARY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 22 1965</b>		25B. NAME OF REGISTRAR <b>W. E. STUBBS</b>		25C. FUNERAL DIRECTOR <b>MARSHALL W. JONES, JR.</b>			
				ADDRESS <b>1735 HARBOR &amp; AVE.</b>			





BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BENEVIEVE

PIZLO

2. DATE AND HOUR PRONOUNCED DEAD

March 19, 1965

1:12 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

345 Folcroft Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Jan. 1, 1906

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City Hos.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Anthony Strzegowski

14. MOTHER'S MAIDEN NAME

Frances Polanowski

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

-

-

16. SOCIAL  
SECURITY NO.

220-05-7381

17. INFORMANT

ADDRESS

Melvin Pizlo 6911 Delvale Pl. 22 zone

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/19/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3/23/65

23C. NAME of CEMETERY or CREMATORY

Holy Rosary

23D. LOCATION

(City, town, or county)

Balto. Co. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 22 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Fialkowski 2007 Eastern Ave.

ADDRESS

Classified

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

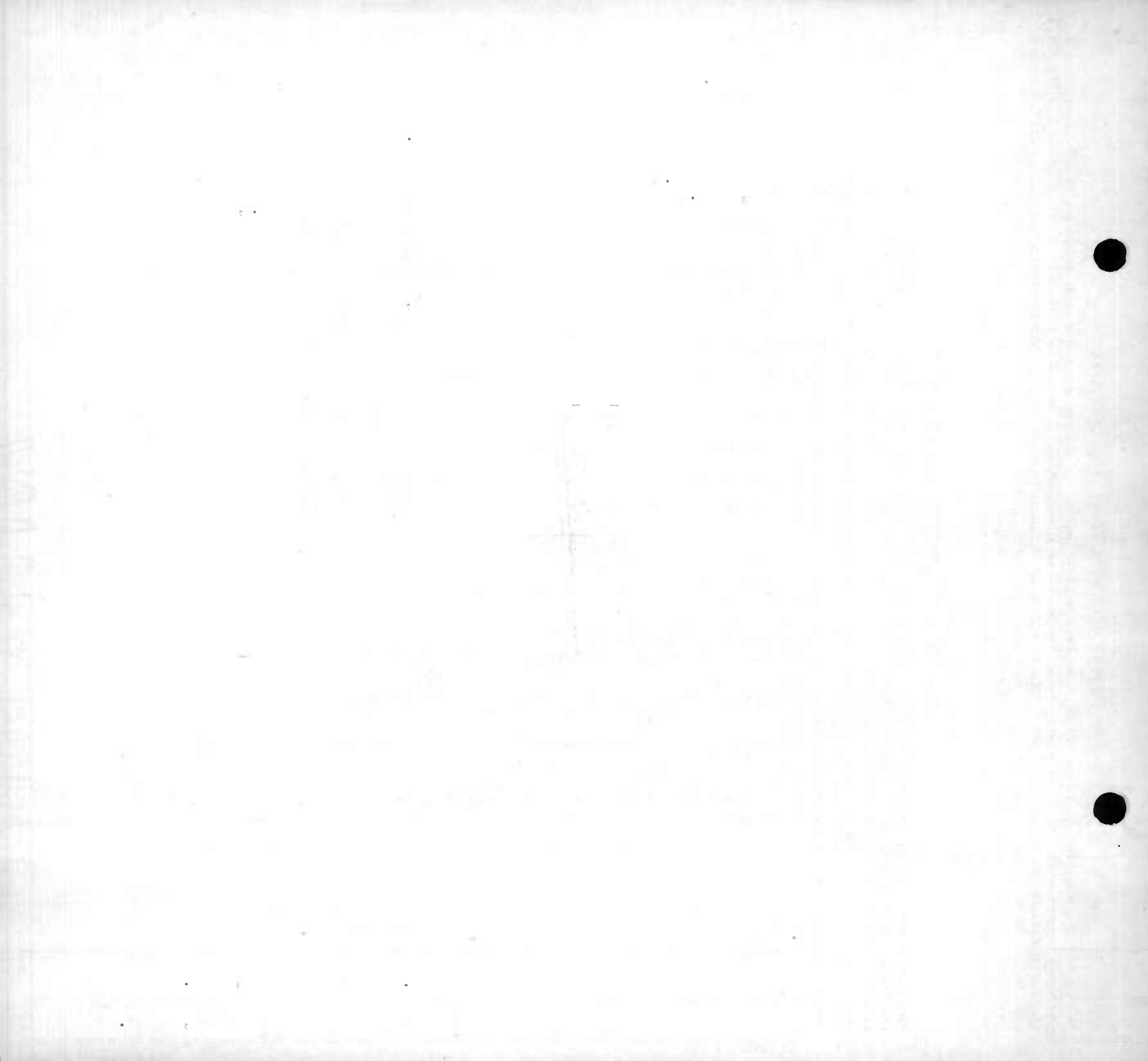
BIRTH NO. 65 2993		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 2993	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) FISHER, JAMES D. KAPELANCZYK -		
2. DATE AND HOUR OF DEATH March 17, 1965 6:00 p.m.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JENKINS MEMORIAL HOSPITAL 100 S Caton Ave. Baltimore, Md. 21229		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 21224			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 2631 Fait Ave.			5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single - Never married		
8. DATE OF BIRTH Dec. 9, 1906			9. AGE (In years last birthday) 59 Yrs		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Designer			11. BIRTHPLACE (State or foreign country) Baltimore, Md		
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME Joseph Kapelanczyk		
14. MOTHER'S MAIDEN NAME Lillian Kopczynski			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 216 01 7993			17. INFORMANT Medical Record Room		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 6 days years years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Jan 21, 1965 to March 17, 1965, that (1) (we) lost saw the deceased alive on March 17, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Raymond Gladue M.D.				23B. DATE SIGNED 3/18/65	
23C. PHYSICIAN'S NAME (Type) J. Raymond Gladue M.D.				23D. ADDRESS Office: 3350 Wilkins Ave. 21229 Jenkins Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-20-65		24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	
24D. LOCATION BALTIMORE C. MD.		25A. DATE REC'D BY HEALTH DEPT. MAR 22 1965			
25B. NAME OF REGISTRAR Gladue		25C. FUNERAL DIRECTOR Raymond L. Kaczorowski			
25D. ADDRESS 2525 FLEET ST					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
BIRTH NO. 65 2994					CERTIFICATE OF DEATH					Registered No. 65 2994					
1. NAME OF DECEASED (Type or Print) HARRY H. WALTON					2. DATE AND HOUR OF DEATH March 17, 1965 8:45 a.m.										
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3205 Elmley Ave., Baltimore, Md., 21213					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 8-01 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3205 Elmley Ave.,										
5. SEX male		6. RACE white		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 6/22/85		9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Bolton, Miss		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME unknown					14. MOTHER'S MAIDEN NAME Hines										
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 218-22-0180					17. INFORMANT Rose Mae Walton (nee Vann) wife, above					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					19. CAUSE OF DEATH Mycardial Infarction Generalised arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH ? ?					
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1-2-1962 to 6-9-1964, that (I) (we) last saw the deceased alive on 6-9-1964 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE Milton C. Lang										23B. DATE SIGNED 3-18-65					
23C. PHYSICIAN'S NAME (Type) Dr. Milton Lang										23D. ADDRESS 2117 Belair Rd.					
24A. BURIAL CREMATION REMOVAL (Specify) Burial					24B. DATE 3/20/65		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem.					24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1965					25B. NAME OF REGISTRAR G. E. Taylor					25C. FUNERAL DIRECTOR Schmunk Funeral Home, Inc. 2331 Brehms Lane					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 2995</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 2995</b>	
M.E. CASE NO. <b>65 2995</b>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Augustus Wayson</b>			2. DATE AND HOUR OF DEATH <b>March 17, 1965 9:30 A. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, 21224</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>X</b>		
5. SEX <b>Male</b>			6. RACE <b>White</b>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>			8. DATE OF BIRTH <b>8-18-86</b>		
9. AGE (In years lost birthday) <b>78</b>			10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>? Wayson</b>		
14. MOTHER'S MAIDEN NAME <b>unknown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>2I4I6500I</b>			17. INFORMANT ADDRESS <b>RECORDS: BCH: 4940 Eastern Avenue #24</b>		
18. <b>454X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion or Pulmonary Embolus</b> (A) DUE TO (B) DUE TO (C) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			INTERVAL BETWEEN ONSET AND DEATH <b>A few Minutes</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Recent Pneumonia</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 4, 3rd 1965</b> to <b>March 17, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 17, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. C. Robert Cooke</b>			23B. DATE SIGNED <b>March 17, 1965</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. C. Robert Cooke</b>			23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-20-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oaklawn</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. STATE (State) <b>Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAR 22 1965</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Harry Dabrowski</b>		25D. ADDRESS <b>1005 Dundalk Ave</b>	



Letter from B.C.H.

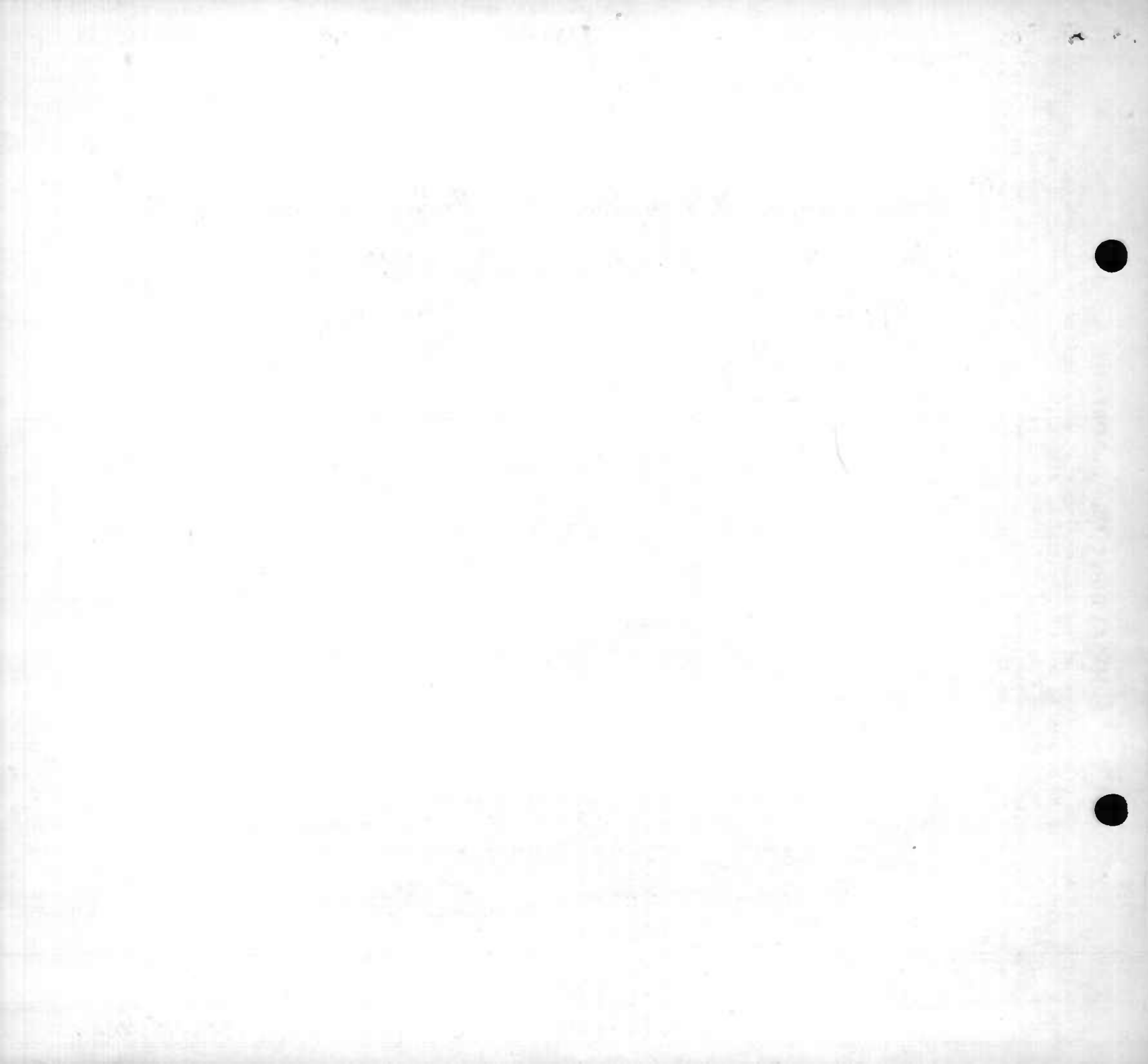
4-2-65

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Baltimore City Health Department	
BIRTH NO.		2996		Registered No. 65 2996	
M.E. CASE NO. 65		2996		24	
1. NAME OF DECEASED (Type or Print)		Julia M Stackelek		2. DATE AND HOUR OF DEATH March 16, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MD		B. COUNTY Balto	
Narford Gardens Nursing Home		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Glen Arm 3300	
D. STREET ADDRESS (If rural, give location)		Narford Rd		Glen Arm, MD	
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH Aug 24, 1905		9. AGE (In years last birthday) 61		10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Theodore Meyer		14. MOTHER'S MAIDEN NAME Clara Chika	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Family Records	
18. 4-22-1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 5 years	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Coronary Arteriosclerosis		DUE TO	
ANTECEDENT CAUSES		(B) Arteriosclerotic Cardiovascular Disease		DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from January 19 62 to March 19 65, that (I) (we) last saw the deceased alive on March 15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Loy M. Zimmerman		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/19/65	
23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman MD		23D. ADDRESS 3202 Narford Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-19-65		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.	
24D. LOCATION (City, town, or county) (State) Balto Co MD		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR 965000	
25C. FUNERAL DIRECTOR C.F. Evanson		ADDRESS 8802 Narford Rd			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# CERTIFICATE OF DEATH

65- 2997  
65 2997

VS 150-REV. 1/1/65



1  
W-230

65 2998

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 2998

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
LLOYD A. WEST		March 18, 1965 6:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland	
University Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore	
		D. STREET ADDRESS (If rural, give location)	
		1143 Wicomico Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Male	White	Married	10/3/1912
9. AGE (In years last birthday)		10. BIRTHPLACE (State or foreign country)	
52		North Carolina	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
North Carolina		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William A. West		Hettie Black	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NWT ✓		-	
17. INFORMANT		ADDRESS	
Mrs Pauline West		-above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Cardiac Tamponade	
ANTECEDENT CAUSES		(B) Fibrinosanguineous Pericarditis.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	3/22/65	Baltimore National Cem.	5501 Frederick Ave
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
MAR 22 1965	John S. Petty, M.D.	John J. Brownson Inc.	Hollins

WALLEY FORGE

PAID ADULTS

1911

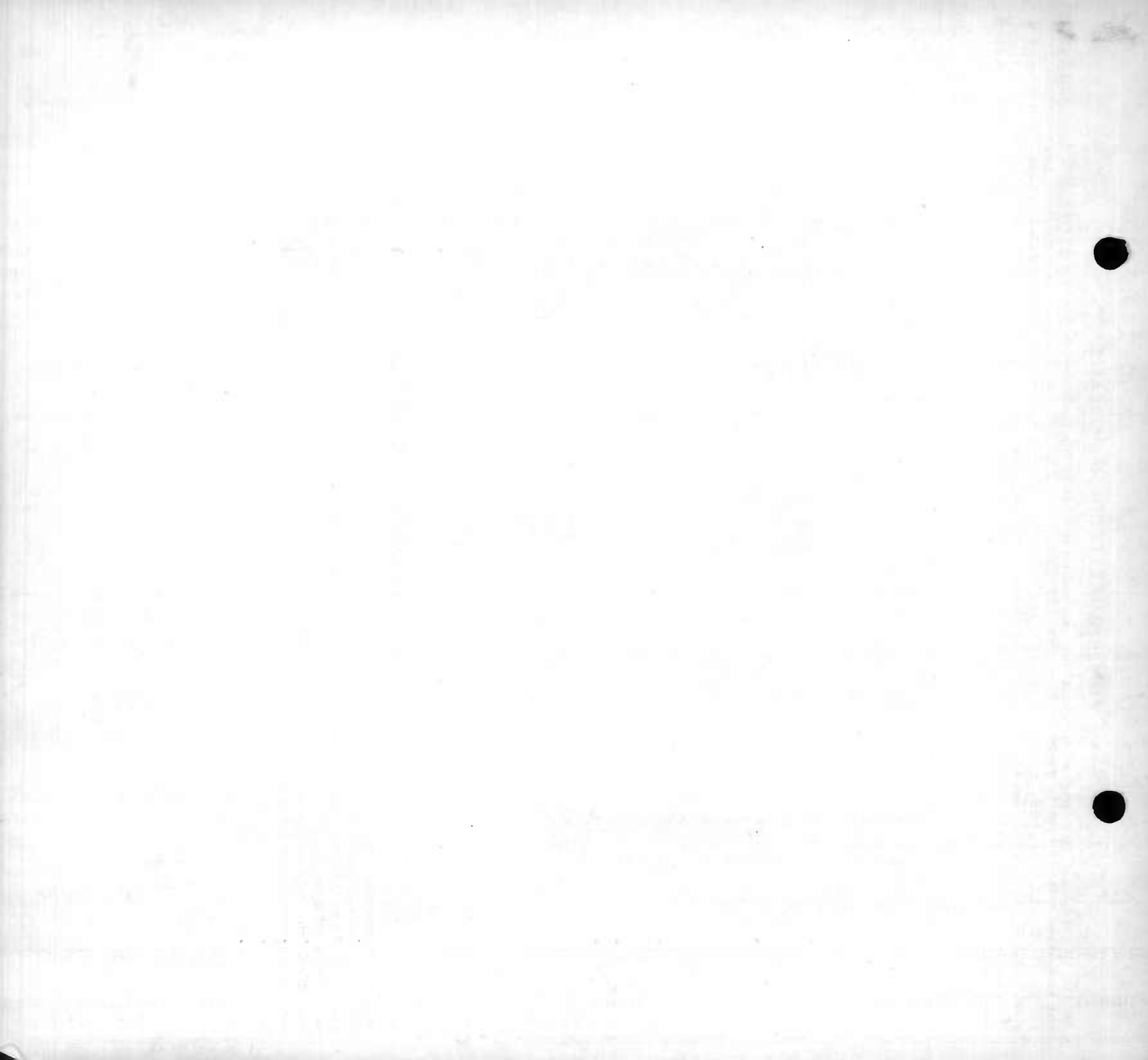
Class 1st



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BIRTH NO. 65 2999		Registered No. 65 2999	
1. NAME OF DECEASED (Type or Print) <b>Agnes Xewell</b>				2. DATE AND HOUR OF DEATH <b>3-18-65 7:05 A.M.</b>			
3. PLACE OF DEATH <b>IN BALTIMORE, MARYLAND</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>AA</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Baltimore General Hosp.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Pasadena 52-00</b>			
D. STREET ADDRESS (If rural, give location) <b>Rt # 11 Box # 120.</b>							
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>3-18-1915</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Moran</b>				14. MOTHER'S MAIDEN NAME <b>Rose Heitzgen</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family - Same</b>			
18. <b>576 X I</b>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) <b>GENERALIZED PERITONITIS</b> DUE TO <b>CAUSE UNDETERMINED</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) _____ DUE TO _____			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>we</del> (this hospital) attended the deceased from <b>3-17</b> 19 <b>65</b> to <b>3-18</b> 19 <b>65</b> , that <del>we</del> (we) last saw the deceased alive on <b>3-18</b> 19 <b>65</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>James F. McCarter</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-18-65.</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAMES F. MCCARTER, M.D.</b>				23D. ADDRESS <b>1213 Light St. - S.B.G.H.</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		24B. DATE <b>3/12/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross</b>		24D. LOCATION (City, town, or county) (State) <b>Balt.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAR 22 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Stankovic</b>		25C. FUNERAL DIRECTOR <b>George E. Kelly</b>		ADDRESS <b>130 E. Fair St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3000				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3000	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PEARL FRANCIS White				2. DATE AND HOUR OF DEATH 3/18/65 7:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY X	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 25-32			
				D. STREET ADDRESS (If rural, give location) 2936 Cherryland Rd. #25			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 5/11/04	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES TUCKER				14. MOTHER'S MAIDEN NAME LAURA CLARK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-32-4212		17. INFORMANT Geraldine Williams (Daughter)		ADDRESS 934 Sengull Ave. #5	
18. 153101 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Pulmonary embolus from leg. (B) Deep. thrombophlebitis. (C) Disseminated carcinoma of colon.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from March 14 19 65 to March 18 19 65, that (we) last saw the deceased alive on March 18 19 65 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE Bruce H. MacPherson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/18/65	
23C. PHYSICIAN'S NAME (Type) BRUCE H. MACPHERSON				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-23-65		24C. NAME of CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1965		25B. NAME OF REGISTRAR Robert S. Tolson		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave.			

